

Case Number:	CM14-0034858		
Date Assigned:	06/20/2014	Date of Injury:	06/24/1992
Decision Date:	09/15/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/20/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 52-year-old female, who has submitted a claim for cervicalgia; carpal tunnel syndrome / double crush syndrome and overuse syndrome, left shoulder; associated with an industrial injury date of June 24, 1992. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of ongoing neck, shoulder and upper extremity pain, with associated numbness and tingling. Physical examination showed, moderate muscle tightness and tenderness along the suboccipital area, bilateral upper trapezius and interscapular musculature. Examination of the cervical spine showed, paravertebral muscle spasm. Examination of the left shoulder showed, tenderness around the anterior glenohumeral region and subacromial space with significant tenderness over the top of the acromioclavicular joint. Examination of the bilateral wrists/hands showed positive palmar compression test with a positive tinel's sign. Treatment to date has included naproxen, cyclobenzaprine, sumatriptan, ondansetron, omeprazole and medrox. Utilization review from February 28, 2014 denied the request for Ondasetron 8mg #60 because the records do not clearly reflect that the patient has experienced nausea and vomiting from previous medication regimen. The request for Tramadol150mg #90 was also denied because the records lack clear documentation of recent urine drug test, risk assessment profile, attempt at weaning/tapering and an updated and signed pain contract bet the provider and claimant and ongoing efficacy with medication use.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Ondasetron 8 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: US Federal Drug Administration.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the US Food and Drug Administration Guidelines, was used instead. The FDA states that Ondansetron is indicated for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy and surgery. However, recent progress notes reviewed did not show that the patient suffered nausea and vomiting secondary to aforementioned conditions. The medical necessity cannot be established due to insufficient information. Therefore, the request for Ondansetron 8mg #60 is not medically necessary.

Tramadol 150 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Tramadol Page(s): 113.

Decision rationale: As stated on pages 113 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Tramadol is indicated for moderate to severe pain. In addition, guidelines do not support ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Given the 1992 date of injury, there was no clear documentation on the duration of opiate use. Records reviewed showed that there was no functional improvement reported or any urine drug screen result prior to the use of Tramadol. In addition, there was no pain management plan submitted. Therefore, the request for Tramadol 150mg #90 is not medically necessary.