

Case Number:	CM14-0037622		
Date Assigned:	06/25/2014	Date of Injury:	01/01/2007
Decision Date:	07/29/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	03/28/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Nevada. 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 injured worker is a 49 year-old female who was reportedly injured on 1/1/2007. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated 2/3/2014 indicates that there are ongoing complaints of neck pain, right shoulder pain, right hand pain, right wrist pain, bilateral elbow pain, left hand pain and left wrist pain. The physical examination demonstrated cervical tenderness at the cervical paravertebral muscles and upper trapezius with spasm pain with terminal motion. Right shoulder tenderness at the right shoulder anteriorly, positive impingement, pain with terminal motion, limited range of motion and weakness. Bilateral elbows: tenderness at the olecranon fossa, left, positive Tinnel's at the elbow. Pain with flexion, Dyesthesia at the two ulnar digits. Bilateral wrist/hands: tenderness at the volar aspect of the wrist and hand. Pain with terminal flexion, weak right grip. No current diagnostic studies are available for review. Previous treatment includes cervical surgery, right shoulder arthroscopy and physical therapy. A request had been made for Cyclobenzaprine Hydrochloride 7.5 mg #120 Ondansetron ODT tablet 8 mg #60 Omeprazole Delayed -Released Capsules 20 mg #120 Ketoprofen Capsules 75 mg, and was not certified in the pre-authorization process 3/14/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine Hydrochloride 7.5 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics. Decision based on Non-MTUS Citation official Disability Guidelines Treatment in Workers Compensation Pain Procedure Summary Low back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26, MTUS (Effective July 18, 2009) Muscle relaxants Page(s): 41, 64.

Decision rationale: The California Medical Treatment Utilization Schedule supports the use of skeletal muscle relaxants such as (cyclobenzaprine) for the short-term treatment of pain, but advises against long-term use. It is noted the injured worker does have muscle spasm and upper trapezius, but given the claimant's date of injury and clinical presentation, the guidelines do not support this request for continued long-term use of this medication for chronic pain. As such, the request is not medically necessary.

Ondansetron ODT tablet 8 mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability guidelines-Treatment in workers Compensation Pain Procedure Summary (last updated 01/07/2014) Pain Procedure Summary.Mosby's Drug Consult.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC - ODG Treatment, Integrated Treatment/Disability Duration Guidelines; Pain (Chronic); Antiemetic - (updated 06/10/14).

Decision rationale: Ondansetron is a serotonin 5-HT₃ receptor antagonist. It is Food and Drug Administration-approved for nausea and vomiting secondary to chemotherapy, radiation treatment, post-operatively and acute gastroenteritis. The Official Disability Guidelines do not recommend this medication for nausea and vomiting secondary to chronic opiate use. Review of the available medical records fail to document any subjective complaints or indication for why this medication was prescribed. As such, this request is not considered medically necessary.

Omeprazole Delayed -Released Capsules 20 mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 68.

Decision rationale: Omeprazole is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications. There are numerous proton pump inhibitors available over the counter without a prescription. The use of this medication, however, is not clearly related to the work injury. After review of the medical records I was unable to

identify complaints of gastrointestinal upset, or intolerance due to the use of a nonsteroidal anti-inflammatory. Therefore, the continuation of this medication is deemed not medically necessary.

Ketoprofen Capsules 75 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 72.

Decision rationale: Ketoprofen is an anti-inflammatory which are the traditional first line of treatment, to reduce pain selectivity and functional restoration can resume, but long-term use of this medication may not be warranted. After review of the medical records of this injured worker I was unable to find documentation concerning this medication and his reduction in pain and improvement in function. Therefore the continued use of this medication is deemed not medically necessary.