MAXIMUS Federal Services

Case Number:	CM14-0071510		
Date Assigned:	07/16/2014	Date of Injury:	11/21/2003
Decision Date:	10/07/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	05/16/2014

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 Orthopedic Surgery, and is licensed to practice 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 records, presented for review, indicate that this 65-year-old individual was reportedly injured on the October 1, 2003. The mechanism of injury was noted as a slip and fall. The most recent progress note, dated June 25, 2014, indicated that there were ongoing complaints of neck pain, radiation to both upper extremities, headaches and left shoulder pain. The physical examination demonstrated 5'6", 190-pound individual who was borderline hypertensive (132/89). The injured employee was noted to be in no acute distress. There was tenderness to palpation in the cervical musculature. A limited range of motion was reported. There was numbness and tingling into the lateral forearm and the radial digits correlating the C6 and C7 dermatomes. There were shoulder changes consistent with impingement syndrome. Diagnostic imaging studies were not presented in this report. Previous treatment included multiple medications, imaging studies and conservative care with injection therapies. A request had been made for multiple medications and was not medically necessary in the pre-authorization process on May 12, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 150 MG # 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113.

Decision rationale: The California MTUS guidelines support the use of Tramadol (Ultram) for short-term use, after there has been evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. A review of the available medical records fails to document any improvement in function or decrease in the pain level with the previous use of Tramadol. Accordingly, the efficacy or utility of this medication has not been established. As such, the request is not considered medically necessary.

Orphenadrine Citrate # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65.

Decision rationale: Orphenadrine is a derivative of diphenhydramine and belongs to a family of antihistamines. It is used to treat painful muscle spasms and Parkinson's. The combination of anti-cholinergic effects and CNS penetration make it very useful for pain of all etiologies including radiculopathy, muscle pain, neuropathic pain, and various types of headaches. It is also useful as an alternative to gabapentin and for those patients who are intolerant of the gabapentin side effects. This medication has been an abuse potential due to a reported euphoric and mood elevating effect, and therefore should be used with caution as a 2nd line option for short-term use in both acute and chronic low back pain. Based on the clinical documentation provided, the clinician does not document trials of any previous anticonvulsant medications or medications for chronic pain such as Gabapentin. Given the MTUS recommendations that this be utilized as a 2nd line agent, the request is deemed not medically necessary.

Omeprazole 20 MG # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), GI Symptom Page(s).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: This is a Proton Pump Inhibitor useful for the treatment of gastroesophageal reflux disease and can be used as a protectorant for those individuals utilizing non-steroidal medications. However, when noting the date of injury and the length of time this medication is being employed and by the fact that there are no complaints of gastric distress, changes to the gastrointestinal tract or any other parameter, there is no data presented to suggest that this medication is needed. Therefore, based on the lack of subjective complaints, there is no medical necessity established for this medication.

Ondansetron 8 MG # 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Ondansteron, and Anti-Emetics

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter

Decision rationale: This medication is approved for treatment of nausea and vomiting secondary to chemotherapy, radiation therapy and postoperatively. These criterions are not noted in the progress notes presented for review. Therefore, while noting that the Official Disability Guidelines does not recommend this medication for nausea and vomiting secondary to chronic opiate use, and based on the clinical information presented for review, there is no medical necessity for this medication.

Terocin Patch # 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105, 112.

Decision rationale: The MTUS guidelines support the use of Topical Lidocaine for individuals with neuropathic pain that have failed treatment with first-line therapy including antidepressants or anti-epileptic medications. A review of the available medical records fails to document signs or symptoms consistent with neuropathic pain or failure with a trial of first-line medications. Therefore, when noting the parameters outlined in the MTUS and by the clinical data presented in the progress notes reviewed, this request is not medically necessary.