

Case Number:	CM14-0088311		
Date Assigned:	07/23/2014	Date of Injury:	09/13/2010
Decision Date:	09/18/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/12/2014

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 and Rehabilitation 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 injured worker is a 36-year-old who reported an injury on September 13, 2010. The mechanism of injury was not provided for clinical review. The diagnoses included low back pain, rule out herniated disc lumbar spine, radiculitis left lower extremity pain. The previous treatment included medication. Within the clinical note dated April 23, 2014, it was reported the injured worker complained of severe pain and spasms in the lumbar spine. Upon the physical examination, the provider noted the injured worker had positive tenderness in the paralumbar musculature. Motor strength was noted to be 5/5 in all muscle groups of the lower extremity. The provider noted the injured worker was unable to perform the heel walk secondary to pain. Deep tendon reflexes were 2+. The range of motion of the lumbar spine was forward flexion at 60 degrees which is normal, extension at 30 degrees which was normal. The provider requested tramadol for pain, Wellbutrin for depression and neuropathic pain, and ondansetron for nausea from NSAIDs (non-steroidal anti-inflammatory drugs) prophylactically. The Request for Authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadal ER 150 mg, sixty count, for date of service April 23, 2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; On-Going Management Page(s): 78.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The guidelines recommend the use of a urine drug screen or in patient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The provider failed to document an adequate and complete pain assessment within the documentation. Therefore, the request for Tramadol ER 150 mg, sixty count, for date of service April 23, 2014, is not medically necessary or appropriate.

Wellbutrin 150 mg, thirty count, for date of service April 23, 2014: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pains Page(s): 13.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend antidepressants as a first line option for neuropathic pain. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request for Wellbutrin 150 mg, thirty count, for date of service April 23, 2014, is not medically necessary or appropriate.

Ondansetron 20 mg, sixty count for date of service April 23, 2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability guidelines.

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

Decision rationale: The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to opioid use. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. There is lack of significant objective findings warranting the medical necessity for the request. Additionally, request submitted failed to provide the frequency of the medication. Therefore, the request for Ondansetron 20 mg, sixty count for date of service April 23, 2014, is not medically necessary or appropriate.