

Case Number:	CM14-0096561		
Date Assigned:	07/28/2014	Date of Injury:	11/21/2003
Decision Date:	08/28/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	06/24/2014

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 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 records, presented for review, indicate that this 65-year-old female was reportedly injured on November 21, 2003. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated June 25, 2014 indicated that there were ongoing complaints of constant pain in the cervical spine that is aggravated by repetitive motions. Left shoulder pain was also noted as well. The physical examination demonstrated a well-developed, well-nourished individual in no acute distress. This was a 5'6, 190 pound individual who was borderline hypertensive (132/89). There were tenderness to palpation and muscle spasm noted in the cervical spine. Positive axial loading compression was positive. Spurling's maneuver was also positive. No instability was identified. Numbness and tingling were noted in the C6 & C7 dermatomes in the bilateral upper extremities. Diagnostic imaging studies were not reviewed. Previous treatment included multiple medications, physical therapy, shoulder steroid injections and will pain management techniques. A request had been made for multiple medications and was not certified in the pre-authorization process on June 11, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 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 Page(s): 82, 113.

Decision rationale: When noting the date of injury, the mechanism of injury, the lack of any specific pathology or pain generator, there is no clinical information presented to support the need for a synthetic opioid analgesic. Furthermore, given the amount of time that this medication has been used and there are no noted increases in terms of decreased pain or lessening symptomatology, the efficacy of this medication has not been established. Therefore, there is no medical necessity for this operation.

Orphenadrine Citrate #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Sedating Muscle Relaxants. Decision based on Non-MTUS Citation ODG -Non Sedating Muscle Relaxants.

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

Decision rationale: This medication is used a derivative of diphenhydramine and belongs to a family of antihistamines. It is used to treat painful muscle spasms and Parkinson's. Structurally, it is related to central acting non-opioid analgesics. The combination of anti-cholinergic effects and central nervous system 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 for those who are intolerant of the gabapentin side effects. Based on the clinical documentation provided, the clinician did not document trials of any previous anticonvulsant medications or medications for chronic pain such as gabapentin. Nor was there any data indicating this is successful in treating the noted complaints. Given the MTUS recommendations that this be utilized as a 2nd line agent, the request is deemed not medically necessary.

Omeprazole 20 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

Decision rationale: Prilosec (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. Gastritis has not been documented as a diagnosis for this claimant. Therefore, the use of this medication is not medically necessary at this time. Further, it is noted that there is no additional clinical indication for non-steroidal medications based on the progress notes presented for review.

Ondansetron 8mg #30: Upheld

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

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, updated July 2014.

Decision rationale: Ondansetron (Zofran) is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy, radiation treatment, post-operatively, and acute gastroenteritis. The records do not reflect that there are any such complaints. Furthermore, the ODG guidelines (MTUS and ACOEM do not address) do not recommend this medication for nausea and vomiting secondary to chronic opiate use. A review of the available medical records failed to document an indication for why this medication was given. As such, this request is not considered medically necessary.

Terocin patch #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56.

Decision rationale: As noted in the MTUS guidelines, topical lidocaine is recommended to address peripheral pain such as postherpetic neuralgia and diabetic neuropathy. Neither of these maladies is noted to this. Additionally, there is no objectification of a specific radiculopathy or neurogenic lesion. Therefore, this is not clinically indicated or medically necessary.