

Case Number:	CM14-0142859		
Date Assigned:	09/10/2014	Date of Injury:	08/17/2012
Decision Date:	04/07/2015	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	09/03/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 female who reported an injury on 08/17/2012. The mechanism of injury was unspecified. Her past treatments included medication and injection. Her diagnoses include cervical discopathy/double Cushing syndrome, right shoulder impingement, and carpal tunnel syndrome. On 05/16/2013, the injured worker complained of continued symptomatology in the right upper extremity. She also noted the injection in her right shoulder provided significant help. The injured worker also indicated complaints of an upset stomach with the use of Naprosyn; however, she continues to utilize it as it offers temporary pain relief allowing her to perform her activities of daily living. Her relevant medications included Naprosyn 550 mg, omeprazole 20 mg, ondansetron 8 mg, cyclobenzaprine 7.5 mg, tramadol 150 mg, and Medrox pain relief 120 grams. The treatment plan included ondansetron for reduction of nausea, cyclobenzaprine for the reduction of muscle spasms, tramadol, and Medrox ointment for pain relief of muscle pain and aches. The Request for Authorization form was submitted on 07/29/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ondansetron 8mg #60 DOS: 5/16/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Pain Procedure Summary.

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

Decision rationale: The request for Ondansetron 8mg #60 DOS: 5/16/13 is not medically necessary. According to the Official Disability Guidelines, Antiemetics (for opioid nausea), is not recommended for nausea and vomiting secondary to chronic opioid use. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for postoperative use. The injured worker was indicated to have continued symptomatology in the right upper extremity. However, there is lack of documentation to indicate the injured worker had nausea and vomiting secondary to chronic opioid use. The injured worker was indicated to have an upset stomach due to the use of Naprosyn. Furthermore, there was lack of documentation to indicate the injured worker was undergoing chemotherapy, radiation treatment, or had a surgical procedure performed. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Cyclobenzaprine Hydrochloride 7.5mg #120 DOS: 5/16/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: The request for Cyclobenzaprine Hydrochloride 7.5mg #120 DOS: 5/16/2013 is not medically necessary. According to the California MTUS Guidelines, Muscle relaxants are recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The injured worker was indicated to have continued symptomatology in the right upper extremity. However, there was lack of documentation upon physical examination indicating the injured worker had muscle spasms or had an acute exacerbation in chronic low back pain. Furthermore, the guidelines do not recommend use due to diminished efficacy and risk for dependence. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Tramadol ER 150mg #90 DOS: 5/16/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going management Page(s): 78.

Decision rationale: The request for Tramadol ER 150mg #90 DOS: 5/16/13 is not medically necessary. According to the California MTUS Guidelines, ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The injured worker was indicated to have been on tramadol for an unspecified duration of time and indicated to have continued symptomatology in the right upper extremity. However, there was lack of documentation of her subjective functional improvement, objective decrease in pain, evidence of monitoring for side effects, and aberrant drug related behavior from opioid use. Furthermore, there was lack of a current urine drug screen for review. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Medrox x 2 120gm DOS: 5/16/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

Decision rationale: The request for Medrox x 2 120gm DOS: 5/16/13 is not medically necessary. According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Furthermore, the guidelines state, Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments, have osteoarthritis, post-herpetic neuralgia, diabetic neuropathy or post-mastectomy pain. The injured worker was indicated to have continued symptomatology in the right upper extremity. However, there was lack of documentation to indicate the injured worker had failed a trial of antidepressants and anticonvulsants. There was also lack of documentation in regard to the injured worker having not responded or was intolerant to other treatments, had osteoarthritis, had postherpetic neuralgia, had diabetic neuropathy, or postmastectomy pain for the formulation use of capsaicin. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.