

Case Number:	CM14-0188361		
Date Assigned:	12/05/2014	Date of Injury:	04/12/2005
Decision Date:	01/16/2015	UR Denial Date:	10/17/2014
Priority:	Standard	Application Received:	11/12/2014

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, has a subspecialty in Interventional Spine 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 patient is a 45-year old male with injury date on 4/12/05. The patient complains of low lumbar pain with radiation into the left lower extremity, with numbness/tingling in the bilateral lower extremities to the level of the foot, pain rated 4/10 with medications, and 8/10 without medications per 7/30/14 report. The patient also has ongoing headaches and insomnia, and complains of increased migraine headaches with auras since Maxalt was denied per 9/24/14 report. Based on the 9/24/14 progress reported provided by the treating physician, the diagnoses are: 1. lumbar disc degeneration 2. Lumbar facet arthropathy 3. Lumbar radiculopathy 4. S/p fusion, L-spine 5. Erectile dysfunction 6. Insomnia 7. Medication related dyspepsia 8. S/p removal of hardware; chronic nausea A physical exam on 9/24/14 showed L-spine tenderness to palpation, and decreased sensitivity to touch along L4-S1 dermatome in bilateral lower extremities. No range of motion testing of the L-spine was included in reports. The patient's treatment history includes medications, epidural steroid injection (bilateral L4-5) with 50-80% improvement for 6 weeks, home exercise program. The treating physician is requesting prescription for flexeril 10mg with 1 refill, and 1 prescription for Ondansetron HCL 4mg #30 with 1 refill. The utilization review determination being challenged is dated 10/17/14. The requesting physician provided treatment reports from 2/12/14 to 11/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription for flexeril 10mg with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril. TUS pg 63-66. Muscle relaxants (for pain) Page(s): 41-42; 63-66.

Decision rationale: This patient presents with lower back pain, left lower extremity pain. The physician has asked for Prescription for Flexeril 10mg With 1 Refill on 9/24/14. The patient has been taking flexeril since 2/12/14 report. Regarding muscle relaxants for pain, MTUS recommends with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, there is no documentation of an exacerbation. The patient is suffering from chronic low back pain and the physician does not indicate that this medication is to be used for short-term. MTUS only supports 2-3 days use of muscle relaxants if it is to be used for an exacerbation. Therefore, 1 Prescription for flexeril 10mg with 1 refill is not medically necessary.

1 Prescription for ondansetron HCL 4mg #30 with 1 refill: 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 chapter, section on Ondansetron (Zofran®) ODG: Pain chapter, section on Antiemetics (for opioid nausea)

Decision rationale: This patient presents with lower back pain, left lower extremity pain. The physician has asked for 1 Prescription for Ondansetron Hcl 4mg #30 With 1 Refills on 9/24/14. The patient has been taking Ondansetron since 2/12/14 report. Regarding Zofran, ODG does not recommended for nausea and vomiting secondary to chronic opioid use, but is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis. In this case, the patient is not undergoing chemotherapy/radiation treatment, and does not have a diagnosis of gastroenteritis. This patient presents with nausea secondary to chronic opioid use for which Zofran is not indicated per ODG guidelines. 1 Prescription for Ondansetron HCL 4mg #30 with 1 refill is not medically necessary.