MAXIMUS Federal Services

Case Number:	CM14-0193988		
Date Assigned:	12/01/2014	Date of Injury:	11/18/2012
Decision Date:	01/14/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/19/2014

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 Occupational Medicine 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:

Injured worker is a female with date of injury 11/18/2012. Per primary treating physician's re-evaluation and progress report dated 9/3/2014, the injured worker has increasing pain of the low back and neck. There is intermittent pain in the cervical spine that is aggravated by repetitive motions of the neck, pushing, pulling, lifting, forward reaching, and working at or above the shoulder level. The pain is characterized as sharp. There is radiation of pain into the upper extremities. There are associated headaches that are migrainosus in nature as well as tension between the shoulder blades. Her pain in unchanged and rated at 7/10. There is intermittent pain in the low back that is aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, prolonged standing, and walking multiple blocks. The pain is characterized as sharp. There is radiation of pain into the lower extremities. Her pain is unchanged and rated at 7/10. There is frequent pain in the left shoulder that is aggravated by forward reaching, lifting, pushing, pulling and working at or above the shoulder level. The pain is characterized as throbbing. Her pain is unchanged and rated at 6/10. There is frequent pain in the left wrist that is aggravated by repetitive motions, gripping, grasping, pushing, pulling and lifting. The pain is reported as throbbing. The pain is unchanged and rated at 6/10. Examination of the cervical spine reveals tenderness at the cervical paravertebral muscles and upper trapezial muscles. Axial loading compression test is positive. Spurling's maneuver is positive. Range of motion is limited with pain. Lumbar spine examination reveals palpable paravertebral muscle tenderness with spasm. Seated nerve root test is positive. Standing flexion and extension are guarded and restricted. Left shoulder examination reveals tenderness around the anterior glenohumeral region and subacromial space. Hawkins and impingement signs are positive. Rotator cuff function appears intact but painful. There is pain with terminal motion with limited range of motion. Left elbow examination reveals tenderness over the lateral epicondyle and olecranon fossa. Tinel's

sign is positive over the cubital tunnel. Range of motion is full but painful. Left wrist examination reveals tenderness at the left wrist first dorsal compartment. There is a positive Finkelstein's sign. There are positive Tinel's and Phalen's signs. Range of motion is full but painful. Diagnoses include 1) cervical/lumbar discopathy 2) sprain and strain left wrist 3) left shoulder impingement syndrome with labral tear 4) electrodiagnostic evidence of chronic C7 nerve root irritation on the right side 5) left lateral epicondylitis and left cubital tunnel syndrome 6) left de Quervain's tenosynovitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fenoprofen Calcium (Nalfon) 400 mg #120: 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 NSAIDs Page(s): 67-71.

Decision rationale: The use of NSAIDs is recommended by the MTUS Guidelines with precautions. NSAIDs are recommended to be used secondary to acetaminophen and at the lowest dose possible for the shortest period in the treatment of acute pain or acute exacerbation of chronic pain as there are risks associated with NSAIDs and the use of NSAIDs may inhibit the healing process. The injured worker has chronic injuries with no change in pain level and no acute injuries reported. The request for Fenoprofen Calcium (Nalfon) 400 mg #120 is determined to not be medically necessary.

Omeprazole 20 mg #120: 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 NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

Decision rationale: Proton pump inhibitors, such as Omeprazole are recommended by the MTUS Guidelines when using NSAIDs if there is a risk for gastrointestinal events. There is no indication that the injured worker has had a gastrointestinal event or is at increased risk of a gastrointestinal event, which may necessitate the use of omeprazole when using NSAIDs. The request for Omeprazole 20 mg #120 is determined to not be medically necessary.

Ondansetron 8 mg #30: Upheld

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

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

Decision rationale: The MTUS Guidelines do not address the use of Ondansetron. The ODG does not recommend the use of antiemetic's for nausea and vomiting secondary to chronic opioid use. Ondansetron is FDA approved for use with nausea as a result of chemotherapy or radiation treatments, post-operative nausea, and acutely in gastroenteritis. The request for Ondansetron 8 mg #30 is determined to not be medically necessary.

Cyclobenzaprine Hydrochloride tablets 7.5 mg #120: 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 Cyclobenzaprine; Muscle Relaxants Page(s): 41, 42, 63, 64.

Decision rationale: Cyclobenzaprine is recommended by the MTUS Guidelines for short periods with acute exacerbations, but not for chronic or extended use. These guidelines report that the effect of cyclobenzaprine is greatest in the first four days of treatment. Cyclobenzaprine is associated with a number needed to treat of three at two weeks for symptoms improvement in low back pain and is associated with drowsiness and dizziness. Chronic use of Cyclobenzaprine may cause dependence, and sudden discontinuation may result in withdrawal symptoms. Discontinuation should include a tapering dose to decrease withdrawal symptoms. This request however is not for a tapering dose. The request for Cyclobenzaprine Hydrochloride tablets 7.5 mg #120 is determined to not be medically necessary.

Tramadol ER 150 mg #90: 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 Opioids; Weaning of Medications Page(s): 74-95, 124.

Decision rationale: Tramadol is a central acting synthetic opioid that exhibits opioid activity with a mechanism of action that inhibits the reuptake of serotonin and norepinephrine with side effects similar to traditional opioids. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical reports do not indicate that there has been significant pain reduction and objective

functional improvement as a result of using tramadol. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Tramadol ER, 150 mg #90 is determined to not be medically necessary.