

Case Number:	CM14-0195841		
Date Assigned:	12/03/2014	Date of Injury:	09/27/2013
Decision Date:	02/06/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	11/21/2014

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:

Patient is a 53 year-old male with date of injury 09/27/2013. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 09/10/2014, lists subjective complaints as pain in the thoracic and lumbar spine with radicular symptoms to the bilateral lower extremities. Objective findings: Examination of the thoracic and lumbar spine revealed palpable paravertebral muscle tenderness with spasm. Seated nerve root test was positive. Standing flexion and extension were guarded and restricted. No clinical evidence of instability. Sensation and strength testing were normal. Diagnosis: 1. Lumbago 2. Thoracic disc displacement. The medical records supplied for review document that the patient has been taking the following medication for at least as far back as five months.

Medication: 1. Fenoprofen calcium 400mg, #120 SIG: 1 PO Q12H 2. Omeprazole 20mg, #120 SIG: 1 PO Q12H 3. Ondansetron 8mg, #30 SIG: 1 PRN 4. Cylcobenzaprine HCL 7.5mg, #120 SIG: 1 PO Q8H 5. Tramadol ER 150mg, #90 1 tablet once a day.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fenoprofen calcium 400 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drug).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. There is no documentation of increased functional ability. Fenoprofen calcium 400 mg #120 is not medically necessary.

Omeprazole 20 mg #120: Upheld

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

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age greater than 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Omeprazole 20 mg #120 is not medically necessary.

Ondansetron 8 mg #30: Upheld

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

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

Decision rationale: There is no documentation that the patient is suffering nausea or vomiting due to any of the approved indications for Ondansetron. Current approved indications include nausea as a result of cancer chemotherapy, radiation of the abdomen or total body radiotherapy, or postoperative nausea/vomiting. Ondansetron not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron 8 mg #30 is not medically necessary.

Cyclobenzaprine HCL 7.5 mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants such as Cyclobenzaprine. The patient has been taking Cyclobenzaprine for an extended period, long past the 2-3 weeks recommended by the MTUS. Cyclobenzaprine is not medically necessary.

Tramadol ER 150 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Tramadol can be added to the medication regimen, but as the immediate-release oral formulation, not as the extended-release formulation. There is no documentation supporting any functional improvement with the continued long-term use of opioids. Tramadol ER 150 mg #90 is not medically necessary.