

Case Number:	CM14-0198337		
Date Assigned:	12/15/2014	Date of Injury:	05/06/2006
Decision Date:	05/22/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	11/25/2014

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 68-year-old male, who sustained an industrial injury on 5/6/2006. He reported low back pain. The injured worker was diagnosed as having status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. Treatment to date has included medications, electrodiagnostic studies, physical therapy, shoe lift, magnetic resonance imaging, and lumbar surgery. He was retired. The request is for Omeprazole DR 20mg capsule #120 (DOS 5/4/10 and 5/24/11), Ondansetron ODT 8mg tablets #30 (DOS 5/4/10), Ondansetron ODT 8mg tablets #30 with 2 refills (DOS 5/24/11), Hydrocodone/Acetaminophen 10/325mg #90 (DOS 5/4/10 and 5/24/11), Medrox rub #120 (DOS 5/4/10) Medrox rub #120 with 2 refills (DOS 5/24/11, Tizanidine HCL 4mg tablet #120 (DOS 5/24/11) Orphenadrine ER 100mg tablets #120 (DOS 5/4/10), Cidaflex tablet #90 (DOS 3/23/10). The records indicate he reported a 50% improvement from therapy and the utilization of a shoe lift. In January 2010, he complained of continued pain in both his lower extremities. The records indicate electrodiagnostic studies revealed L5-S1 radiculopathy, and a magnetic resonance imaging revealed spondylolisthesis with severe spinal stenosis. In May of 2010, the patient had complained of continued pain with decreased range of motion as well as weakness and numbness in the lower extremities. In March 2011, he was reported to have been doing well following lumbar surgery. The treatment plan included physical therapy. In May of 2011, he was waiting for hardware removal and had an increase in Cardizem.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request (DOS: 5/4/10) for Omeprazole DR Capsule #120: 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, Proton-pump inhibitor.

Decision rationale: The injured worker has reported low back pain. He has diagnoses with status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. His treatment has included medications, electrodiagnostic studies, physical therapy, shoe lift, MRI, and lumbar surgery. The patient has had a 50% improvement from therapy and the utilization of a shoe lift. In 01/2010, he complained of continued pain in his lower extremities. In 05/2010, the patient complained of continued pain with decreased range of motion, as well as weakness and numbness in the lower extremities. In 03/2011, he reported to have been doing well following lumbar surgery. In 05/2011, he was awaiting hardware removal and increased his Cardizem. In regard to the request for omeprazole, the Official Disability Guidelines note that proton pump inhibitors are recommended for patients at risk for gastrointestinal events. In general, the use of PPIs should be limited to the recognized indications and used to the lowest dose for the shortest period of time possible. There is no documentation of the patient having any gastrointestinal events or being at risk for gastrointestinal events. Therefore, the retrospective request for (DOS: 5/4/10) for Omeprazole DR Capsule #120 is not medically necessary.

Retrospective request (DOS: 5/24/11) for Omeprazole DR Capsule #120: 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, Proton pump inhibitor.

Decision rationale: The injured worker has reported low back pain. He has diagnoses with status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. His treatment has included medications, electrodiagnostic studies, physical therapy, shoe lift, MRI, and lumbar surgery. The patient has had a 50% improvement from therapy and the utilization of a shoe lift. In 01/2010, he complained of continued pain in his lower extremities. In 05/2010, the patient complained of continued pain with decreased range of motion, as well as weakness and numbness in the lower extremities. In 03/2011, he reported to have been doing well following lumbar surgery. In 05/2011, he was awaiting hardware removal and increased his Cardizem. In regard to the request for omeprazole, the Official Disability Guidelines note that proton pump

inhibitors are recommended for patients at risk for gastrointestinal events. In general, the use of PPIs should be limited to the recognized indications and used to the lowest dose for the shortest period of time possible. There is no documentation of the patient having any gastrointestinal events or being at risk for gastrointestinal events. Therefore, the retrospective request for (DOS: 5/24/11) for Omeprazole DR Capsule #120 is not medically necessary.

Retrospective request (DOS: 5/4/10) for Ondansetron 8mg tablet #30: 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, Antiemetics.

Decision rationale: The injured worker has reported low back pain. He has diagnoses with status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. His treatment has included medications, electrodiagnostic studies, physical therapy, shoe lift, MRI, and lumbar surgery. The patient has had a 50% improvement from therapy and the utilization of a shoe lift. In 01/2010, he complained of continued pain in his lower extremities. In 05/2010, the patient complained of continued pain with decreased range of motion, as well as weakness and numbness in the lower extremities. In 03/2011, he reported to have been doing well following lumbar surgery. In 05/2011, he was awaiting hardware removal and increased his Cardizem. In regard to the request for ondansetron, the request is not supported. The Official Disability Guidelines note that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. It is recommended for acute use as noted below per FDA guideline recommendations. It is recommended for chemotherapy, radiation treatment, postoperative use, as well as gastroenteritis. There is no documentation that the patient has any nausea and vomiting due to postoperative issues. Therefore, the request for (DOS: 5/4/10) for Ondansetron 8mg tablet #30 is not medically necessary.

Retrospective request (DOS: 5/24/11) for Ondansetron ODT 8mg tablet #30 with 2 refills: 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, Antiemetics.

Decision rationale: The injured worker has reported low back pain. He has diagnoses with status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. His treatment has included medications, electrodiagnostic studies, physical therapy, shoe lift, MRI, and lumbar surgery. The patient has had a 50% improvement from therapy and the utilization of a shoe lift. In 01/2010, he complained of continued pain in his lower extremities. In 05/2010, the patient

complained of continued pain with decreased range of motion, as well as weakness and numbness in the lower extremities. In 03/2011, he reported to have been doing well following lumbar surgery. In 05/2011, he was awaiting hardware removal and increased his Cardizem. In regard to the request for ondansetron, the request is not supported. The Official Disability Guidelines note that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. It is recommended for acute use as noted below per FDA guideline recommendations. It is recommended for chemotherapy, radiation treatment, postoperative use, as well as gastroenteritis. There is no documentation that the patient has any nausea and vomiting due to postoperative issues. Therefore, the request for (DOS: 5/24/11) for Ondansetron ODT 8mg tablet #30 with 2 refills is not medically necessary.

Retrospective request (DOS: 5/4/10) for Hydrocodone/Acetaminophen 10-325mg #90:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-95. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Antiemetics.

Decision rationale: The injured worker has reported low back pain. He has diagnoses with status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. His treatment has included medications, electrodiagnostic studies, physical therapy, shoe lift, MRI, and lumbar surgery. The patient has had a 50% improvement from therapy and the utilization of a shoe lift. In 01/2010, he complained of continued pain in his lower extremities. In 05/2010, the patient complained of continued pain with decreased range of motion, as well as weakness and numbness in the lower extremities. In 03/2011, he reported to have been doing well following lumbar surgery. In 05/2011, he was awaiting hardware removal and increased his Cardizem. In regards to the request for hydrocodone /acetaminophen, the request is not supported. The California Medical Treatment Guidelines recommend the ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The pain assessments should include current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. There is no documentation of injured worker's functional status, appropriate medication use or side effects. There is no documentation the injured worker was receiving a urine drug screen to monitor for appropriate drug use. There is also no documentation of a complete pain assessment. Therefore, the request for hydrocodone/acetaminophen 10/325mg #90 is not medically necessary.

Retrospective request (DOS: 5/24/11) for Hydrocodone/Acetaminophen 10-325mg #90:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 76-95.

Decision rationale: The injured worker has reported low back pain. He has diagnoses with status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. His treatment has included medications, electrodiagnostic studies, physical therapy, shoe lift, MRI, and lumbar surgery. The patient has had a 50% improvement from therapy and the utilization of a shoe lift. In 01/2010, he complained of continued pain in his lower extremities. In 05/2010, the patient complained of continued pain with decreased range of motion, as well as weakness and numbness in the lower extremities. In 03/2011, he reported to have been doing well following lumbar surgery. In 05/2011, he was awaiting hardware removal and increased his Cardizem. In regards to the request for hydrocodone /acetaminophen, the request is not supported. The California Medical Treatment Guidelines recommend the ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The pain assessments should include current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. There is no documentation of injured worker's functional status, appropriate medication use or side effects. There is no documentation the injured worker was receiving a urine drug screen to monitor for appropriate drug use. There is also no documentation of a complete pain assessment. Therefore, the request for hydrocodone/acetaminophen 10/325mg #90 is not medically necessary.

Retrospective request (DOS: 5/4/10) for Medrox rub #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical
Analgesics Page(s): 111-113.

Decision rationale: The injured worker has reported low back pain. He has diagnoses with status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. His treatment has included medications, electrodiagnostic studies, physical therapy, shoe lift, MRI, and lumbar surgery. The patient has had a 50% improvement from therapy and the utilization of a shoe lift. In 01/2010, he complained of continued pain in his lower extremities. In 05/2010, the patient complained of continued pain with decreased range of motion, as well as weakness and numbness in the lower extremities. In 03/2011, he reported to have been doing well following lumbar surgery. In 05/2011, he was awaiting hardware removal and increased his Cardizem. The California Medical Treatment Guidelines note that topical analgesics are recommended as an option as indicated below. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There is no documentation provided that the injured worker has been intolerant or has not responded to other treatments. Therefore, the request for Medrox rub #120 is not medically necessary.

Retrospective request (DOS: 5/24/11) for Medrox rub #120 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The injured worker has reported low back pain. He has diagnoses with status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. His treatment has included medications, electrodiagnostic studies, physical therapy, shoe lift, MRI, and lumbar surgery. The patient has had a 50% improvement from therapy and the utilization of a shoe lift. In 01/2010, he complained of continued pain in his lower extremities. In 05/2010, the patient complained of continued pain with decreased range of motion, as well as weakness and numbness in the lower extremities. In 03/2011, he reported to have been doing well following lumbar surgery. In 05/2011, he was awaiting hardware removal and increased his Cardizem. The California Medical Treatment Guidelines note that topical analgesics are recommended as an option as indicated below. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There is no documentation provided that the injured worker has been intolerant or has not responded to other treatments. Therefore, the request for Medrox rub #120 with 2 refills is not medically necessary.

Retrospective request (DOS: 5/24/11) for Tizanidine HCL 4mg tablet #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants. 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 injured worker has reported low back pain. He has diagnoses with status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. His treatment has included medications, electrodiagnostic studies, physical therapy, shoe lift, MRI, and lumbar surgery. The patient has had a 50% improvement from therapy and the utilization of a shoe lift. In 01/2010, he complained of continued pain in his lower extremities. In 05/2010, the patient complained of continued pain with decreased range of motion, as well as weakness and numbness in the lower extremities. In 03/2011, he reported to have been doing well following lumbar surgery. In 05/2011, he was awaiting hardware removal and increased his Cardizem. The California Medical Treatment Guidelines note that muscle relaxants are recommended for non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations of patients with chronic low back pain. Most cases muscle relaxants showed no benefit beyond NSAIDs and pain and overall improvement. Anti-spastic and antispasmodics are used to decrease muscle spasms and spasticity. Tizanidine is a centrally alpha

2 adrenergic agonist that is FDA approved for management of spasticity. There is no documentation of how long the injured worker has been using tizanidine. The request also exceeds guideline recommendation for short-term use. There is also no documentation the injured worker has any muscle spasms or spasticity. Therefore, the request for tizanidine HCL 4mg tablet #120 is not medically necessary.

Retrospective request (DOS: 5/4/10) for Orphenadrine ER 100mg tablet #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants. 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 injured worker has reported low back pain. He has diagnoses with status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. His treatment has included medications, electrodiagnostic studies, physical therapy, shoe lift, MRI, and lumbar surgery. The patient has had a 50% improvement from therapy and the utilization of a shoe lift. In 01/2010, he complained of continued pain in his lower extremities. In 05/2010, the patient complained of continued pain with decreased range of motion, as well as weakness and numbness in the lower extremities. In 03/2011, he reported to have been doing well following lumbar surgery. In 05/2011, he was awaiting hardware removal and increased his Cardizem. The California Medical Treatment Guidelines note that muscle relaxants are recommended for non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations of patients with chronic low back pain. Most cases muscle relaxants showed no benefit beyond NSAIDs and pain and overall improvement. Antispasmodic and antispasmodics are used to decrease muscle spasms and spasticity. California Medical Treatment Guidelines also note that orphenadrine is similar to diphenhydramine but has greater anticholinergic effects. The mode of action is not clearly understood. The guidelines also note that the dose is 100 mg twice a day. The request exceeds guideline recommendations for daily dosage. It also exceeds guideline recommendations for short-term use. Therefore, the request for orphenadrine ER 100mg tablet 120 is not medically necessary.

Retrospective request (DOS: 5/4/10) for Cidaflex tablet #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate Page(s): 50.

Decision rationale: The injured worker has reported low back pain. He has diagnoses with status post lumbar spine surgery, insomnia secondary to chronic pain, and sciatica. His treatment has included medications, electrodiagnostic studies, physical therapy, shoe lift, MRI, and lumbar surgery. The patient has had a 50% improvement from therapy and the utilization of a shoe lift.

In 01/2010, he complained of continued pain in his lower extremities. In 05/2010, the patient complained of continued pain with decreased range of motion, as well as weakness and numbness in the lower extremities. In 03/2011, he reported to have been doing well following lumbar surgery. In 05/2011, he was awaiting hardware removal and increased his Cardizem. The California Medical Treatment Guidelines note that glucosamine and chondroitin sulfate is recommended as an option given its low risk in patients with moderate arthritis pain especially from knee osteoarthritis. The injured worker does have low back pain. However, there is no documentation that the injured worker has any osteoarthritis that would require the need for glucosamine and chondroitin sulfate. Therefore, the request for Cidaflex tablet #90 is not medically necessary.