MAXIMUS Federal Services

Case Number:	CM14-0209427		
Date Assigned:	01/09/2015	Date of Injury:	07/09/2013
Decision Date:	02/10/2015	UR Denial Date:	11/10/2014
Priority:	Standard	Application Received:	12/15/2014

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 Rehab, has a subspecialty in Pain Medicine, Spinal Cord Medicine and is licensed to practice in Massachusetts. 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 claimant is a 35 year-old male who has a history of a work injury occurring on 07/09/13 when, while working for the [redacted] and changing a gas meter he had sharp pain. Treatments included chiropractic care for the cervical and lumbar spine. He was seen on 07/19/14. He was having intermittent neck and frequent to constant low back pain with constant shooting pain to the groin. Physical examination findings included cervical and lumbar spine tenderness. There was interspinous ligament swelling at C7/T1. There was pain with cervical spine range of motion. There was trapezius muscle tenderness and tightness with lumbar paraspinal muscle spasms. Cervical foraminal compression testing, shoulder depression testing, and cervical traction testing was positive. There were positive Patrick, FABERE, and Kemp tests. Imaging results were reviewed. Recommendations included a course of chiropractic treatment, an electrical stimulation unit, and a back support. On 09/18/14 pain was rated at 7/10. Physical examination findings included paraspinal muscle tenderness and spasms with positive seated nerve root test. There was guarded and restricted spinal range of motion. There were left lower extremity symptoms of tingling and numbness. Authorization for a lumbar epidural steroid injection was requested. Medications were prescribed. On 10/16/14 pain was again rated at 7/10. Physical examination findings appear unchanged. Medications were refilled. The claimant was continued out of work.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 68-71.

Decision rationale: The claimant is more than one year status post work-related injury and continues to be treated for neck, low back, and groin pain. Guidelines recommend an assessment of GI symptoms and cardiovascular risk when NSAIDs are used. In this case, the claimant is not taking an oral NSAID. Therefore, the continued prescribing of Omeprazole is not medically necessary.

Ondansetron 8mg ODT #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 (Chronic), Antiemetics, Other Medical Treatment Guideline or Medical Evidence: Ondansetron prescribing information.

Decision rationale: The claimant is more than one year status post work-related injury and continues to be treated for neck, low back, and groin pain. Medications included Tramadol ER. Indications for prescribing Zofran (ondansetron) are for the prevention of nausea and vomiting associated with cancer treatments or after surgery. The claimant has not had recent surgery and is not being treated for cancer. ODG addresses the role of antiemetics in the treatment of opioid induced nausea. In this case, although the claimant is being prescribed Tramadol medication, there is no history of opioid induced nausea. Therefore, the use of this medication is not medically necessary.

Tramadol extended release 150mg #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Opioids, dosing Page(s): 76-80; 86.

Decision rationale: The claimant is more than one year status post work-related injury and continues to be treated for neck, low back, and groin pain. Medications included Tramadol ER. Guidelines indicate that when an injured worker has reached a permanent and stationary status or maximal medical improvement that does not mean that they are no longer entitled to future medical care. When prescribing controlled substances for pain, satisfactory response to treatment

may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Tramadol ER is a sustained release formulation and would be used to treat baseline pain which is present in this case. The requested dosing is within guideline recommendations. In this case, there are no identified issues of abuse, addiction, or poor pain control. There are no inconsistencies in the history, presentation, the claimant's behaviors, or by physical examination. Therefore, the continued prescribing of Tramadol ER is medically necessary.

Eszopiclone #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)-Treatment of Insomnia

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Mental Illness & Stress, Insomnia (2) Mental Illness & Stress, Insomnia treatment

Decision rationale: The claimant is more than one year status post work-related injury and continues to be treated for neck, low back, and groin pain. Medications included Lunesta (eszopiclone).The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. In this case, the nature of the claimant's sleep disorder is not provided. There is no assessment of factors such as sleep onset, maintenance, quality, or next-day functioning. Whether the claimant has primary or secondary insomnia has not been determined. Therefore, based on the information provided, the continued prescribing of Lunesta is not medically necessary.

Cyclobenzaprine Hydrochloride 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 Cyclobenzaprine (Flexeril); Muscle relaxants Page(s): 41; 63.

Decision rationale: The claimant is more than one year status post work-related injury and continues to be treated for neck, low back, and groin pain. Medications include cyclobenzaprine. Cyclobenzaprine is closely related to the tricyclic antidepressants. It is recommended as an option, using a short course of therapy and there are other preferred options when it is being prescribed for chronic pain. Although it is a second-line option for the treatment of acute exacerbations in patients with muscle spasms, short-term use only of 2-3 weeks is recommended. In this case, the quantity being prescribed is consistent with long term use and was therefore not medically necessary.