

Case Number:	CM15-0106641		
Date Assigned:	06/11/2015	Date of Injury:	02/14/2013
Decision Date:	08/19/2015	UR Denial Date:	05/14/2015
Priority:	Standard	Application Received:	06/03/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 53 year old male, who sustained an industrial injury on 2/14/13. The injured worker has complaints of low back pain radiating to the lower extremities. The documentation noted that there is tenderness in the upper trapezius muscles. There is severe tenderness in the lumbar paravertebral muscles and slight spasm of the lumbar paravertebral muscles. The diagnoses have included cervical spondylosis; cervical radiculitis and status post microdiscectomy/laminotomy, L4-5 with severe residual low back pain and radiculopathy. Treatment to date has included electrodiagnostic studies and magnetic resonance imaging (MRI) evidence of nerve root impingement at multiple levels; magnetic resonance imaging (MRI) of the cervical spine on 11/2/13 showed extensive degenerative disc changes and uncovertebral joint arthrosis resulting in moderate to severe spinal canal stenosis at C5-6 with deformity of the cord at this level; Prevacid; Ondansetron; Cyclobenzaprine and Lunesta. The request was for Prevacid 30mg #120; Ondansetron 8mg #30; Cyclobenzaprine 7.5mg #120 and Lunesta 1mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prevacid 30mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors (PPIs) Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69 of 127.

Decision rationale: Regarding the request for Prevacid, California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested Prevacid is not medically necessary.

Ondansetron 8mg #30: Upheld

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

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

Decision rationale: Regarding the request for Ondansetron (Zofran), California MTUS guidelines do not contain criteria regarding the use of antiemetic medication. ODG states that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Guidelines go on to recommend that Ondansetron is approved for postoperative use, nausea and vomiting secondary to chemotherapy, and acute use for gastroenteritis. Within the documentation available for review, there is no indication that the patient has nausea as a result of any of these diagnoses and no indication of efficacy from prior use. In the absence of clarity regarding those issues, the currently requested Ondansetron (Zofran) is not medically necessary.

Cyclobenzaprine 7.5mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 41, 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66 of 127.

Decision rationale: Regarding the request for Cyclobenzaprine (Flexeril), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Cyclobenzaprine (Flexeril) is not medically necessary.

Lunesta 1mg #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-Treatment In Workers' Compensation.

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

Decision rationale: Regarding the request for Lunesta, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no current description of the patient's insomnia, no discussion regarding what behavioral treatments have been attempted, and no statement indicating how the patient has responded to treatment. Furthermore, there is no indication that Lunesta is being used for short-term use as recommended by guidelines. In the absence of such documentation, the currently requested Lunesta is not medically necessary.