

Case Number:	CM15-0198990		
Date Assigned:	10/19/2015	Date of Injury:	03/02/2009
Decision Date:	12/29/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/09/2015

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: New York, California

Certification(s)/Specialty: Emergency Medicine

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 51 year old male who sustained an industrial injury on 03-02-2009. According to a progress report dated 09-01-2015, the injured worker reported neck pain that radiated down the bilateral upper extremities that was accompanied by tingling frequently in the bilateral upper extremities to the level of the hands. He reported frequent muscle spasms in the neck area. Low back pain radiated down the bilateral lower extremities. Pain was accompanied by numbness frequently in the bilateral lower extremities to the level of the feet. He also reported pain bilaterally in the legs. He also reported teeth grinding and testicle pain. Pain was rated 7 on a scale of 1-10 with medications since the last visit and 10 on average without medications since the last visit. Pain was reported as worsened since this last visit. He reported gastroesophageal reflux disease related medications associated gastrointestinal upset. He reported frequent severe nausea. He reported ongoing limitations due to pain in self-care, hygiene, activity, ambulation, hand function and sleep over the past month that was rated 7 (on a scale of 1-10 where "0" is no interference and "10" is unable to carry on any activities.) He reported that the use of anti-seizure class, H2-blocker, muscle relaxant and opioid medication was helpful. He reported 60% improvement due to this therapy. Areas of functional improvement as a result of this therapy included: ability to attend church, bathing, brushing teeth, caring for pet, cleaning, climbing stairs, driving, exercising at home, gardening, mood, reading, shopping, sitting, sleeping, sleep in bed, standing, standing in line, tying shoes, walking in neighborhood and washing dishes. Quality of life had been improved. Diagnoses included cervical radiculopathy, lumbar facet arthropathy, lumbar radiculopathy, ilioinguinal neuralgia right, diabetes mellitus, erectile

dysfunction, gastroesophageal reflux disorder, medication related dyspepsia, obstructive sleep apnea, chronic pain other, thoracic spine herniated nucleus pulposus, chronic nausea vomiting, rule out inguinal hernia, adjustment disorder with mixed anxiety and depressed mood, chronic grinding of teeth due to severe pain and diabetes related visual disturbance (difficulty seeing near). The injured worker used CPAP nightly due to obstructive sleep apnea established by 03-26-2014 sleep study. The injured worker was currently not working and was considered totally temporarily disabled. The treatment plan included optometrist, replacement equipment for CPAP machine and TENS unit pads, Gabapentin, Hydrocodone, Metformin, Ondansetron, Senokot-S, Tizanidine, Tramadol ER, Vitamin D and Zolpidem. Medications by all providers included Ambien, Metformin, Norco, Ondansetron, Tizanidine, Tramadol ER, Vitamin D, Senokot-S and Gabapentin. An authorization request dated 07-27-2015 and 09-01-2015 was submitted for review. The requested services included bilateral C5-6 cervical epidural, replacement equipment for CPAP machine, TENS unit replacement pads x 4, Ambien, Gabapentin, Metformin, Ondansetron, Norco, Tizanidine, Tramadol ER, Vitamin D and Senokot-S. On 09-30-2015, Utilization Review non-certified the request for replacement equipment for CPAP, TENS unit pads x 4, Ondansetron 4 mg #30, Tizanidine 2 mg #30, Tramadol ER 100 mg #30, Vitamin D 200 units #60 and Senokot 8.6-50 mg #90 and authorized the request for internal medicine evaluation and Gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Replacement equipment for CPAP: 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 <http://www.uptodate.com/contents/initiation-of-positive-airway-pressure-therapy-for-obstructive-sleep-apnea-in-adults?source=machineLearning&search=CPAP&selectedTitle=1~150§ionRank=3&anchor=H21#H21>.

Decision rationale: CA MTUS and ODG are silent on this topic. The IW was diagnosed with sleep apnea following a sleep study evaluation in March 2014. The above reference states, "patient's early experience with PAP therapy appears to influence ongoing acceptance and adherence. Contributing factors include patient education, close follow-up, treatment of complications, comfort of the patient-device interface, subjective success of the patient's first night using PAP at home, and support of the patient's bed partner." The records do not discuss improvement of sleep or restfulness since its implementation. The guidelines recommend close follow-up, but the submitted documentation does not support this has occurred. Without the support of the documentation of ongoing monitoring, the request for replacement CPAP equipment is not medically necessary.

TENS unit pads x4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The CA MTUS ACOEM guidelines recommend against the use of TENS units for the management of low back complaints. Additionally, the chronic pain management guidelines recommend against this therapy as a primary treatment, but supports a one-month home based trial. It is unclear from the documentation how low the IW has been using this unit. The documentation does not discuss the frequency of use or improvement of symptoms. There is no decrease in medications prescribed or change in work status. Specific benefits related to the use of the unit are not discussed. Without this documentation, the improvements from the unit are not known. As such, the request for TENS patches are not medically necessary.

Ondansetron 4mg, #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 ODG - pain chapter, antiemetics.

Decision rationale: The MTUS does not provide direction for the use of antiemetics. The Official Disability Guidelines recommends against their use for nausea presumed to be caused by chronic opioid intake. Per the FDA, ondansetron is indicated for nausea caused by chemotherapy, radiation treatment, postoperative use, and acute gastroenteritis. This injured worker does not have an FDA-approved indication. The treating physician has not provided an adequate evaluation of any condition causing nausea. The necessary indications are not present per the available guidelines and evidence and the ondansetron is not medically necessary.

Tizanidine 2mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: CA MTUS guideline states muscle relaxers should be used "as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." Guidelines further state "Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time." With respect to Za, guideline state "is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain." Documentation supports ongoing prescribing of zanaflex. There is not documentation to support the IW's response to use of zanaflex. As noted, the

guidelines recommend against use for chronic pain. Documentation does not support a new or acute exacerbation of injury. The request is not medically necessary.

Tramadol ER 100mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for neuropathic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for neuropathic pain.

Decision rationale: CA MTUS, chronic pain guidelines, offer very specific guidelines for the ongoing use of opiate pain medication to treat chronic pain. These recommendations state that the lowest possible dose be used as well as "ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects." It also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. Tramadol is recommended for the treatment of moderate to severe pain. It is not recommended as a first line agent for treatment. The chart materials do not include a list of all the analgesic medications currently used or the IW response to each medication. There is not discussion of the IW functional status in relation to the different medications. It is unclear how long the IW has been taking Tramadol. The chart does not include urine drug screens. With the absence of this supporting documentation, the request for Tramadol is not medically necessary.

Vitamin D 200units, #60: 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 section, vitamins.

Decision rationale: The CA MTUS does not provide direction for the use of Vitamin D. The treating physician has stated that there is a Vitamin D deficiency although no actual test results were presented. The Official Disability Guidelines recommends against vitamin supplementation unless there is a documented deficiency. Such a deficiency is not supported based on reviewed records. The Vitamin D is determined not medically necessary, as the records do not document a deficiency.

Senokot S 8.6/50mg, #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.senokot.com/html/main/index/asp>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: CA MTUS chronic pain guidelines recommend prophylactic treatment of constipation when prescribing opiates for analgesia. The IW has been on opiate medications for a minimum of 6 months and has been taking stool softeners during this time. There is no documentation in the record relating the IW bowel habits. Ongoing prescribing of Colace in the setting of narcotics is appropriate. However, opiate prescriptions should be closely monitored with ongoing assessments of functional improvements related to prescribed medications. As such, the ongoing use of a Colace is dependent upon the ongoing use of opiates. Additionally, the request does not include dosing frequency or duration. Without this documentation, the request for Colace with refills is not medically necessary.