

Case Number:	CM15-0022399		
Date Assigned:	02/12/2015	Date of Injury:	07/15/2013
Decision Date:	05/15/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/06/2015

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, Montana

Certification(s)/Specialty: Internal Medicine, Infectious Disease

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 42 year old male with a sustained work related injury dated 11/17/2009. The mechanism of injury was not stated. The current diagnoses include lumbar spine stenosis, lumbar discopathy, left knee osteoarthritis, right knee patellar tendinitis, status post laminectomy at T11-12 on 07/12/2011, status post thoracic fusion on 07/19/2011, extension of laminectomy on 07/23/2011, thoracic wound debridement on 08/20/2011, diffuse thoracic spine stenosis and hemiparesis, thoracic hardware infection, bilateral shoulder impingement, bilateral upper extremity tendonitis, and panthoracic spinal stenosis. The injured worker presented on 07/24/2014 for a follow-up evaluation. It was noted that the injured worker was wheelchair bound. There was no change in lower extremity symptomatology. Upon examination, there was an antalgic gait, tenderness to palpation, limited range of motion, crepitus on motion of the shoulder, positive impingement maneuvers, 4/5 motor weakness, intact sensation in the bilateral upper extremities, significant paralumbar tenderness, positive straight leg raise bilaterally at 40-45 degrees, limited lumbar range of motion, diminution of plantar strength, diminished ankle reflex, and decreased sensation in the posterolateral heel and foot. Treatment recommendations included hardware removal and continuation of the current medication regimen. There was no Request for Authorization Form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (DOS: 12/8/14) Ondansetron 8mg, #10: Upheld

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

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, Ondansetron, Antiemetic.

Decision rationale: The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to chronic opioid use. It is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. In addition, acute use is FDA approved for gastroenteritis. The injured worker does not maintain a diagnosis of gastroenteritis. It does not appear that the injured worker meets criteria for the requested medication as outlined by the Official Disability Guidelines. The Physician Progress Note dated 12/08/2014 was not provided for this review. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

Retrospective (DOS: 12/8/14) Tramadol ER #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 78, 93-94, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. There was no documentation of objective functional improvement despite the ongoing use of tramadol ER. The physician progress note dated 12/08/2014 was not provided for review. Previous urine toxicology reports documenting evidence of patient compliance and nonaberrant behavior were not provided. There is also no strength or frequency listed in the request. Given the above, the request is not medically appropriate.

Retrospective (DOS: 12/8/14) Naproxen Sodium 550mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain.

For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. There was no documentation of an acute exacerbation of chronic pain. The Physician Progress Note dated 12/08/2014 was not provided. There was also no frequency listed in the request. Guidelines do not support long term use of muscle relaxants. As such, the request is not medically appropriate.

Retrospective (DOS: 12/8/14) Pantoprazole 20mg, #90: Upheld

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

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

Decision rationale: California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency listed in the request. As such, the request is not medically appropriate.

Retrospective (DOS: 12/8/14) Cyclobenzaprine 7.5mg, #90: Upheld

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

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

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. The Physician Progress Note dated 12/08/2014 was not provided for this review. There was no evidence of palpable muscle spasm or spasticity upon examination. There is also no frequency listed in the request. As such, the request is not medically necessary.