

Case Number:	CM15-0213462		
Date Assigned:	11/03/2015	Date of Injury:	10/23/2003
Decision Date:	12/18/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/29/2015

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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 54 year old male who sustained an industrial injury on 10-23-2003. A review of medical records indicates the injured worker is being treated for lumbar disc disease with bilateral lower extremity radiculopathy, bilateral lower extremity radiculopathy, status post L1-2 laminectomy-discectomy, status post IDET at L4-5 and L5-S1, status post left ulnar nerve transposition, cervical sprain strain syndrome, spinal cord stimulator implant, bilateral knee sprain strain, and medication induced gastritis. Medical records dated 9-14-2015 noted severe pain into his mid to lower back, which radiated down. Pain was rated 6 out of 10 on current medications. He requires assistance with activities of daily living. Pain was worse at the prior visit. Physical examination noted tenderness to the lumbar spine with decreased range of motion. Pinprick wheel was decreased along the left posterior lateral thigh and posterior lateral calf in approximately the L5-S1 distribution bilaterally. Treatment has included Dilaudid, Valium, and Zofran since at least 3-23-2015. Utilization review form dated 9-29-2015 non-certified Zofran 8mg #20, Valium 5mg #90, and Dilaudid 2mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zofran 8mg #20: 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), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk, Opioids, criteria for use, SNRIs (serotonin noradrenaline reuptake inhibitors). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Antiemetics (for opioid nausea).

Decision rationale: Ondansetron (Zofran) is an antiemetic used to decrease nausea and vomiting. Nausea is a known side effect of chronic opioid use and some Serotonin-norepinephrine reuptake inhibitors (SNRIs). ODG does not recommend use of antiemetic for "nausea and vomiting secondary to chronic opioid use." Additionally, "This drug is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use." There is no evidence that patient is undergoing chemotherapy/radiation treatment or postoperative. MTUS is specific regarding the gastrointestinal symptoms related to NSAID usage. If criteria are met, the first line treatment is to discontinue usage of NSAID, switch NSAID, or consider usage of proton pump inhibitor. There is no documentation provided that indicated the discontinuation of NSAID or switching of NSAID occurred. Additionally, Ondansetron is not a proton pump inhibitor and is not considered first line treatment. As such, the request for Zofran 8mg #20 is not medically necessary.

Valium 5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Benzodiazepines.

Decision rationale: Valium is the brand name version of diazepam, a benzodiazepine. MTUS states, "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks." ODG states regarding benzodiazepines, "The potential for adverse outcomes increases with concurrent prescribing of medications with sedative properties; thus, concomitant prescribing of opioids, Tramadol, benzodiazepines, and other sedating medications (such as H₁ blocker antihistamines) is not recommended." Records indicate that the patient has been on Valium in excess of the 4-week limit. The treating physician does not indicate any extenuating circumstances for why this patient should continue to be on Valium. The request Valium 5mg #90 is in excess of the guidelines. As such, the request for Valium 5mg #90 is not medically necessary.

Dilaudid 2mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, criteria for use, Opioids, dosing, Opioids, specific drug list. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids.

Decision rationale: Per MTUS, Dilaudid is the brand name version of Hydromorphone, which is a pure agonist/short acting opioid and "they are often used for intermittent or breakthrough pain." ODG does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment 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. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not document the following: the least reported pain over the period since last assessment, intensity of pain after taking opioid, how long it takes for pain relief or how long pain relief lasts. As such, the request for Dilaudid 2mg #60 is not medically necessary.