MAXIMUS Federal Services

Case Number:	CM15-0043929		
Date Assigned:	03/13/2015	Date of Injury:	09/15/2013
Decision Date:	05/08/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	03/09/2015

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: California, Washington
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 55-year-old male who reported injury on 09/15/2013. The mechanism of injury was cumulative trauma. There was a Request for Authorization submitted for review dated 01/30/2015. The documentation of 01/22/2015 revealed the injured worker as prescribed Nalfon for inflammation and pain. The injured worker was prescribed omeprazole for GI symptoms. The injured worker was prescribed ondansetron for nausea associated with headaches that are present for chronic cervical spine pain. The injured worker was given cyclobenzaprine for palpable muscle spasms during examination and tramadol for acute severe pain. The injured worker was prescribed Lunesta to treat temporary insomnia. Additional documentation dated 01/12/2015 revealed the injured worker had symptoms in his bilateral wrists and hands aggravated by repetitive motion. The injured worker had constant pain in the cervical spine aggravated by repetitive motion. The injured worker had frequent pain in the bilateral shoulders and bilateral knees as well as bilateral feet. The physical examination revealed a positive Spurling's maneuver and palpable paravertebral muscle tenderness with spasms in the cervical spine. The diagnoses included cervicalgia and cervical discopathy as well as carpal tunnel and double crush syndrome. The documentation indicated the injured worker had difficulty sleeping due to night time paresthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omperazole 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and cardiovascular risk.

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend proton pump inhibitors for injured workers who are at intermediate risk or high risk for gastrointestinal events. Injured workers with no risk factors and no cardiovascular disease do not require the use of a proton pump inhibitor. Additionally, they indicate that treatment for dyspepsia secondary to NSAID therapy includes a proton pump inhibitor. The clinical documentation submitted for review indicated the injured worker had GI symptoms. However, there was a lack of documentation of efficacy for the requested medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for omeprazole 20mg #120 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 Official Disability Guidelines (ODG); Pain Chapter, Antiemetics (for opioid nausea).

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

Decision rationale: The Official Disability Guidelines indicate that ondansetron is not recommended for the treatment of nausea and vomiting secondary to chronic opioid use. It is recommended for postoperative use. The clinical documentation submitted for review indicated the injured worker had utilized the medication and was utilizing the medication for nausea associated with headaches. However, there was a lack of documented efficacy for the requested medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for ondansetron 8mg #30 is not medically necessary.

Cyclobenzaprine Hydrochloride 7.5 QTY 120: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had objective findings of muscle spasm on examination. The efficacy for the requested medication was not provided. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for cyclobenzaprine hydrochloride 7.5mg #120 is not medically necessary.

Tramadol ER 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of objective functional improvement and an objective decrease in pain. There was a lack of documentation indicating the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for tramadol ER 150mg #90 is not medically necessary.

Eszopiclone 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 (ODG) Treatment in Workers Compensation (TWC); Pain.

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

Decision rationale: The Official Disability Guidelines indicate that eszopiclone is recommended for the short term treatment of insomnia. The duration of use could not be established. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for eszopiclone 1mg #30 is not medically necessary.