

Case Number:	CM15-0056847		
Date Assigned:	04/01/2015	Date of Injury:	06/01/2007
Decision Date:	05/21/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	03/25/2015

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

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 46 year old male, who sustained an industrial injury on June 1, 2007. The injured worker was diagnosed as having status post posterior lumbar interbody fusion L4-S1, status post C3-4/C5-6 cervical total disc replacement, status post L5-S1 total disc replacement, and status post left knee arthroscopy with debridement. Treatment to date has included cervical, lumbar, and left knee surgeries; physical therapy; and medications. Currently, the injured worker complains of increasing neck pain that radiates to his right side and right fascial area with headaches, constant pain in the cervical spine, intermittent pain in the low back, and intermittent pain in the left knee. The Primary Treating Physician's report dated February 18, 2015, noted the injured worker reporting that his neck pain was worsening, the low back pain was improving, and the left knee pain was unchanged. Physical examination was noted to show the cervical spine with palpable paravertebral muscle tenderness with spasm, a positive axial loading compression test, a positive Spurling's maneuver, a positive Tinel's sign at the elbows, and limited range of motion with pain. The lumbar spine was noted to have pain with range of motion terminal motion. The left knee was noted to have tenderness in the joint line, with crepitus with painful range of motion, and McMurray's and patellar grind test positive. Cervical x-rays were noted to show total disc replacement at C3-C4 and C5-C6 with mild spondylosis at C6-C7. Lumbar spine x-rays were noted to show a posterior interbody fusion at L4 to S1 with evidence of previous disc replacement at L5-S1, and no evidence of hardware failure. The treatment plan was noted to include a MRI of the cervical spine, bilateral upper extremity electromyography (EMG)/nerve conduction velocity (NCV), request for authorization for three

Synvisc injections to the left knee, continued physical therapy, and continued medications. The Physician noted on March 9, 2015, the following pharmacological agents were necessary for the symptomatic relief of the injured worker's persistent pain from his industrial injury, including Nalfon, Omeprazole, Ondansetron, Cyclobenzaprine, Tramadol, Lunesta, Tylenol #3, Sumatriptan Succinate, Cymbalta, Norco, levofloxacin, and Methoderm gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fenoprofen calcium 400mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): s 67-68.

Decision rationale: According to the California MTUS Guidelines, NSAIDs are recommended as an option for short term symptomatic relief. The documentation submitted for review indicated the injured worker had pain to the cervical spine, lumbar spine, and left knee. However, there was no documentation noting efficacy in terms of pain relief and functional improvement with the use of this medication. Consequently, the request is not supported. Additionally, the request did not specify duration and frequency of use. As such, the request for Fenoprofen calcium 400 mg #120 is not medically necessary.

Omeprazole 20mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: According to the California MTUS Guidelines, proton pump inhibitors, such as omeprazole, is recommended for those at risk for or has a history of gastrointestinal events. The documentation submitted for review did not indicate the injured worker had gastrointestinal issues. Additionally, efficacy was not outlined. Consequently, the request is not supported. Additionally, the request did not specify duration and frequency of use. As such, the request for Omeprazole 20 mg #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, Pain Chapter, Ondansetron (Zofran).

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

Decision rationale: According to the Official Disability Guidelines, Ondansetron is FDA approved for nausea and vomiting secondary to chemotherapy and radiation, postoperative use, and gastroenteritis. The clinical documentation submitted for review did not indicate that the injured worker had such conditions. Moreover, the documentation did not indicate efficacy of the use of this medication. Consequently, the request is not supported. Additionally, the request did not specify duration and frequency of use. As such, the request for Ondansetron 8 mg #30 is not medically necessary.

Cyclobenzaprine Hydrochloride 7.5mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): s 63-64.

Decision rationale: According to the California MTUS Guidelines, Cyclobenzaprine is not recommended for more than 3 weeks. The documentation submitted for review indicated the injured worker had pain and spasm. However, efficacy was not outlined in terms of decreased spasms, decreased pain, and functional improvement. Moreover, there is no documentation noting how long the injured worker had been on this medication. Consequently, the request is not supported. Additionally, the request did not specify duration and frequency of use. As such, the request for Cyclobenzaprine Hydrochloride 7.5 mg #120 is not medically necessary.