

Case Number:	CM15-0086517		
Date Assigned:	05/08/2015	Date of Injury:	07/17/2007
Decision Date:	06/30/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/05/2015

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: 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 50-year-old male an industrial injury on December 17, 2013. Previous treatment includes Shockwave therapy to the left shoulder, cervical spine, lumbar spine, left foot and leg, home care, Tempur-Pedic adjustable bed, wheelchair, epidural injections, surgical intervention, and medications. A pain management consultation on March 18, 2015 revealed that the injured worker complains of neck and left shoulder pain. The quality of pain is described as severe, sharp, dull and burning. He reports that the pain radiates into the left shoulder and left arm and that he experiences headaches. He has associated paresthesia in the left hand and numbness and weakness in the left arm. The evaluating physician notes that the injured worker has left hemiparesis following his cervical spine surgical intervention and is in a wheelchair. On examination, the injured worker has asymmetry of the neck and shoulders with tilting of the head and neck to the left. He has tenderness to palpation over the trapezial area and restricted range of motion in the cervical spine. Diagnoses associated with the request include degeneration of the cervical intervertebral disc, cervical disc displacement, and post laminectomy syndrome of the cervical region. The treatment plan includes medications of Ambien, tizanidine, Zofran, cervical steroid injection and Ultram.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #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).

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

Decision rationale: There are no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Ambien is a benzodiazepine agonist approved for insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Long-term use may lead to dependency. Patient has been on Ambien chronically. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. The prescription is excessive and not consistent with short-term use or attempts to wean patient off medication. The chronic use of Ambien is not medically appropriate and is not medically necessary.

Tizanidine 4mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/antispasmodics Page(s): 60.

Decision rationale: Zanaflex (Tizanidine) is an antispasmodic muscle relaxant. It is FDA approved for muscle spasms. As per MTUS guidelines, muscle relaxants should be used for short-term use and for flare-ups only. Patient has been on this medication chronically and prescription is not consistent with weaning or intermittent use. Tizanidine is not medically necessary.

Zofran 4mg #60: 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).

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

Decision rationale: There are no relevant sections in the MTUS Chronic pain or ACOEM guidelines concerning this topic. Ondansetron/Zofran is an anti-nausea medication. As per Official Disability Guide (ODG), anti emetics should only be used for short-term nausea associated with opioids. Long-term use is not recommended. There is no documentation provided by treating physicians about improvement with this medication but information showing lack of efficacy with continued complaints of nausea. Pt is also chronically on Zofran. Chronic use of Ondansetron is not medically necessary.

Ultram ER 100mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-79.

Decision rationale: Tramadol/Ultram is a Mu-agonist, an opioid-like medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation does not meet the appropriate documentation of all criteria. There is no documentation of objective improvement in pain, activity of daily living and monitoring of side effects. There is in fact no documentation of any pain assessment. There is no documentation of long-term plan or improvement in activity. There is no documentation of monitoring for abuse, pain contract, CURES review or monitoring of side effects. Due to lack of required documentation, this prescription for Ultram is not medically necessary.