

Case Number:	CM14-0129595		
Date Assigned:	09/03/2014	Date of Injury:	12/05/2011
Decision Date:	10/22/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/14/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 was reportedly injured on December 5, 2011. The most recent progress note dated July 24, 2014, indicates that there are ongoing complaints of low back pain described as 4/10. The physical examination demonstrated a 5'8", 265 pound individual who is hypertensive (143/97). The injured employee described as well-nourished, well-developed in no acute distress. There is tenderness to palpation in the lower lumbar spine with muscle spasm noted. Straight leg testing is negative. There is no instability noted. Diagnostic imaging studies were not reported. Previous treatment includes multiple medications, physical therapy and other pain management interventions. A request was made for multiple medications and was not certified in the pre-authorization process on July 21, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg Q12H PRN #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

Decision rationale: Prilosec (Omeprazole) is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications. The last several progress notes do not indicate any complaints of gastrointestinal distress. There is no evidence of physical examination of any gastritis or complaints. Therefore, there is no medical necessity established for this medication. The request is not medically necessary.

Ondansetron 8mg ODT #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/pro/ondansetron-and-dextrose.html

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 updated October, 2014

Decision rationale: Ondansetron (Zofran) is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy, radiation treatment, post-operatively, and acute gastroenteritis. The ODG guidelines do not recommend this medication for nausea and vomiting secondary to chronic opiate use. Review of the available medical records fail to document an indication for why this medication was given. As such, this request is not medically necessary.

Orphenadrine citrate Q8H #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65 of 127.

Decision rationale: This is a medication that is from the family of antihistamines. It is used to treat painful muscle spasms and Parkinson's disease. However, while noting some muscle spasms are identified on physical examination there is no demonstrated efficacy as the physical examination has unchanged over the last several months. Therefore, there is no definite evidence presented to suggest that this medication has any efficacy whatsoever. As such the medical necessity has not been established. The request is not medically necessary.

Tramadol ER 150mg daily as needed #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113 of 127.

Decision rationale: The California MTUS guidelines support the use of Tramadol (Ultram) for short-term use after there is evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. A review of the available medical records fails to document any improvement in function or decrease in pain level with the previous use of Tramadol. As such, the request is not medically necessary.