

Case Number:	CM14-0142676		
Date Assigned:	09/10/2014	Date of Injury:	05/13/2009
Decision Date:	10/14/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	09/03/2014

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 & Rehabilitation and Pain Medicine and is licensed to practice in California. 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 65-year-old female, who reported an injury on 05/13/2009 due to an unknown mechanism. Diagnoses were cervical disc displacement, lumbar disc displacement. Physical examination on 07/09/2014 revealed complaints of cervical spine aggravated by repetitive motions. The pain was characterized as sharp and radiated to the upper extremities. The pain was reported to be an 8/10. There was complaint of low back pain that was reported to be a 7/10. The injured worker reported the pain was worsening. Examination of the cervical spine revealed tenderness and spasm. Range of motion was limited due to pain. Examination of the lumbar spine revealed tenderness to palpation of the paravertebral muscle with spasms. Seated nerve root test was positive. Medications were not reported. Treatment plan was a request for physical therapy and to continue medications as directed. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac Sodium ER 100mg #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
Page(s): 67.

Decision rationale: The decision for Diclofenac Sodium ER 100mg #120 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicates that NSAIDs are recommended for short term symptomatic relief of back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and objective decrease in pain. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. Functional improvement was not reported. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

Omeprazole 20mg #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 Page(s): 69.

Decision rationale: The decision for Omeprazole 20mg #120 is not medically necessary. According to the California Medical Treatment Utilization Schedule Guidelines, proton pump inhibitors may be recommended for injured workers with dyspepsia secondary to NSAID therapy or for those taking NSAID medications who are at moderate to high risk for gastrointestinal events. It was not reported that the injured worker was having gastrointestinal events. The request does not indicate a frequency for the medication. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request 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 Disabilities Guidelines (ODG)-TWC Pain, Mosby's Drug Consult.

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

Decision rationale: The decision for Ondansetron 8mg #30 is not medically necessary. The Official Disability Guidelines do not recommend ondansetron (Zofran) for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is common with the use of opioids. The side effects tend to diminish over days to week if continued exposure. Studies of opioids' adverse effects including nausea and vomiting are limited to short term duration and have limited application to long term use. If nausea and vomiting remain prolonged, other etiologies of these symptoms should be evaluated. As the guidelines do not recommend Zofran for nausea and vomiting secondary to opioid use, the medication would not be indicated. The efficacy of

this medication was not provided. The provider's request did not indicate the frequency of the medication. Therefore, this request is not medically necessary.

Cyclobenzaprine Hydrochloride Tablets 7.5 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official disabilities guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Cyclobenzaprine Page(s): 41, 64.

Decision rationale: The decision for Cyclobenzaprine Hydrochloride Tablets 7.5 mg #120 is not medically necessary. The California Medical Treatment Utilization Schedule states that cyclobenzaprine (Flexeril) is recommended for a short course of therapy. Flexeril is more effective than placebo in the management of back pain; however, the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. This medication is not recommended to be used for longer than 2 to 3 weeks. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. The guidelines state that this medication should not be used longer than 2 to 3 weeks. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, this request is not medically necessary.

Tramadol ER 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Identifies recommendations of opioids use for chronic pain..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol; Ongoing Management Page(s): 82, 93;94, 113; 78.

Decision rationale: The decision for Tramadol ER 150mg #90 is not medically necessary. The California Medical Treatment Utilization Schedule states central analgesic drugs, such as tramadol (Ultram) are reported to be effective in managing neuropathic pain and it is not recommended as a first line oral analgesic. The medical guidelines recommend that there should be documentation of the 4 A's for ongoing monitoring, including analgesic, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The 4 A's for ongoing monitoring were not reported. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.