

Case Number:	CM14-0148379		
Date Assigned:	09/18/2014	Date of Injury:	04/14/2002
Decision Date:	12/24/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/12/2014

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, has a subspecialty in Interventional Spine 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 patient is a 55 year-old male with the date of injury of 04/17/2002. The patient presents with pain in his neck, radiating down upper extremities bilaterally. The neck pain radiates up the head and causes tense headaches. The patient rates his neck pain as 8/10, aggravated by repetitive motions of his neck. There is tenderness over paravertebral muscle with spasm. The range of neck motion is limited with pain. The patient reports having pain in his lower back, radiating down lower extremities bilaterally. The range of lumbar flexion and extension is guarded and restricted. There is 4 strength in the EHL and ankle plantar flexors, L5 and S1 innervated muscles. The patient rates his back pain as 9/10. The patient reports having pain in his knees bilaterally with buckling. The patient rates his knee pain as 7/10, aggravated by squatting, kneeling or walking. There is tenderness in the joint line. Per 08/12/2012 progress report, the patient is working with restrictions. "Specific restrictions are standing, sitting, bending, use of hands, etc.)" None of the reports mention current medications except the list of requesting for Nalfon, Cyclobenzaprine HCL, Ondansetron and Omeprazole, Tramadol on 08/20/2014. MRI of Lumbar on 09/04/2013 showed developmental spinal stenosis throughout the lumbar spine canal and bilateral neuroforaminal stenosis at L5-S1, with left L4-L5 neuroforaminal stenosis, Patients diagnoses on 08/12/2014 includes int derangement knee nos, lumbago cervicgia and sprain hip & thigh nos. The utilization review determination being challenged is dated on 08/28/2014. Two treatment reports were provided from 08/12/2014 to 08/26/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

OMEPRAZOLE 20 MG #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISKS Page(s): 68,69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The patient presents with pain in his neck, lower back and knees bilaterally. The patient is s/p multiple surgeries including both of shoulder surgeries (dates of surgeries are not provided). MTUS guidelines page 69 recommends prophylactic use of PPI's when appropriate GI assessments have been provided. The patient must be determined to be at risk for GI events, such as age > 65 years, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The physician prescribes this medication "for upset stomach, in conjunction with the pain and anti-inflammatory medication, in order to protect the stomach and to prevent any GI complication from taking these medications. The patient describes a history of some epigastric pain and stomach upset while using NSAIDs in the past for chronic pain." In this case, the physician indicates that the patient has GI symptoms with NSAIDs with history of GI complications. Recommendation is for authorization.

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

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) chapter, Antiemetics (for opioid nausea)

Decision rationale: The patient presents with pain in his neck, lower back and knees bilaterally. The patient is s/p multiple surgeries including both of shoulder surgeries (dates of surgeries are not provided). The MTUS and ACOEM Guidelines do not discuss Ondansetron. However, ODG Guidelines has the following regarding antiemetic, "Not recommended for nausea and vomiting secondary to chronic opioid use, it is recommended for acute use as noted below per FDA-approved medications. Ondansetron (Zofran): This drug is a serotonin 5-HT3 receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use." The physician is prescribing Ondansetron for nausea associated with headaches, radiating from his neck pain. Given the lack of support from the guidelines for the use of this medication for nausea associated with chronic pain, recommendation is for denial.

CYCLOBENZAPRINE HCl 7.5 MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: The patient presents with pain in his neck, lower back and knees bilaterally. The patient is s/p multiple surgeries including both of shoulder surgeries (dates of surgeries are not provided). MTUS guidelines page 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. The most commonly prescribed antispasmodic agents are Carisoprodol, Cyclobenzaprine, Metaxalone, and Methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." MTUS guidelines allow no more than 2-3 weeks of muscle relaxants to address flare up's. In this case, the physician indicates that this medication is to be used for a short term and the patient should not take this medication more than three per day. # 120 tablets are for 40 days, even the patient takes maximum amounts every day. Recommendation is for denial.

TRAMADOL ER 150 MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 78, 88-89.

Decision rationale: The patient presents with pain in his neck, lower back and knees bilaterally. The patient is s/p multiple surgeries including both of shoulder surgeries (dates of surgeries are not provided). Regarding chronic opiate use, MTUS guidelines page and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. There are no discussions regarding all 4A's; No Cures or UDS reports, for example. Given the lack of sufficient documentation demonstrating efficacy for chronic opiate use, the patient should slowly be weaned as outlined in MTUS guidelines. Recommendation is for denial.