

Case Number:	CM14-0168157		
Date Assigned:	10/15/2014	Date of Injury:	04/28/2009
Decision Date:	11/18/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/13/2014

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 Internal 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 (IW) is a 60-year-old man who was working as a firefighter/paramedic. He has a date of injury of April 28, 2009. The mechanism of injury is not documented in the medical record for this review. The Primary Treating Physician's Progress Note (PR-2) dated August 25, 2014 indicated that the IW reports frequent pain in the low back and hips. The pain radiates to the bilateral lower extremities and is rated 7/10. Upon physical examination, there is palpable paravertebral muscle tenderness with spasm noted. Seated nerve root test and Fabere's are positive. Standing flexion and extension are guarded and restricted; there is tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as the foot with L5 and S1 dermatomal patterns. Ankle reflexes are asymmetric. Diagnosis is documented as lumbago, and hip pain. An authorization dated September 5, 2014 indicated that the authorization request for physical therapy 2 times a week for 6 weeks for lumbosacral spine and hips was approved. The provider notes states that the course, scope, frequency, and duration of treatment will be determined via correspondence between the therapist and provider. Medication refills are ordered on a separate order form according to the note. The plan of care was discussed with the IW, but was not detailed in the medical record for this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fenoprofen Calcium (Nalfon) 400mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines recommendations for NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI and Cardiovascular Risk Page(s): 67-68.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment guidelines, Nalfon 400 mg #120 is not medically necessary. The guidelines recommend non-steroidal anti-inflammatory drugs at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy especially in patients with gastrointestinal and cardiovascular risk factors. In this case, the most recent documentation from 2014 is missing entries regarding non-steroidal anti-inflammatory use and/or indications. Additionally, there is no evidence of objective functional benefit with prior non-steroidal anti-inflammatory drug use in the record. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines Fenoprofen Calcium (Nalfon) 400 mg #120 is not medically necessary.

Ondansetron ODT 8mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG - TWC Pain Procedure Summary last updated 08/04/2014; regarding antiemetics (for opioid nausea)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Anti-emetics Other Medical Treatment Guideline or Medical Evidence: Zofran:
<http://www.nlm.nih.gov/medlineplus/druginfo/meds/a601209.html>

Decision rationale: Pursuant to the MedlinePlus Ondansetron 8mg #30 (Zofran) and the official disability guidelines, Zofran is not medically necessary. Zofran, and antiemetic, is not recommended for nausea and vomiting secondary to chronic opiate use. It is recommended for surgically based nausea and vomiting and emesis from chemotherapy. Zofran is otherwise extremely safe and effective. In this case, medical record does not set out clinical indications for Zofran and the progress notes contain no information regarding Zofran's prior use or continued use. Based on the clinical information medical record and the peer-reviewed evidence-based guidelines, Ondansetron ODT (Zofran) 8mg #30 is not medically necessary.

Cyclobenzaprine Hydrochloride 7.5mg #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 Cyclobenzaprine Page(s): 41.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment guidelines in the Official Disability Guidelines, Cyclobenzaprine 7.5 mg #120 is not medically necessary. The guidelines recommend non-sedating muscle relaxants as a second line option for short-term use of two low back pain and for short-term use of acute exacerbations in patients with chronic low back. In this case, the injured worker had muscle tenderness on physical examination. The medical record however is missing clinical information indicating why the injured worker was taking cyclobenzaprine long-term. The ODG recommends cyclobenzaprine not be used for longer than 2 to 3 weeks. Ideally, the injured worker should be weaned from this medication. Based on the clinical information in the medical record, Cyclobenzaprine 7.5 mg #120 is not medically necessary.

Tramadol ER 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; criteria for use for a therapeutic trial of opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for opiate use Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Criteria For Opiate Use

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, Tramadol ER 150 mg #90 is not medically necessary. Opiates are recommended as the standard of care for treatment of moderate to severe pain. Long-term use of opiates needs to have accompanying documentation with an ongoing review and subsequent recommendations as to ongoing management. In this case, the medical record is missing documentation of pain relief, functional status, appropriate medication use and side effects. A detailed pain assessment is also missing from the medical record. The injured worker reports recurrent pain in the lower back and hips. On physical examination there is tenderness and spasm noted. However, there is no objective functional benefit with prior medication use documented in the medical record. There is no risk assessment profile, attempted meaning/tapering of Tramadol. Injured worker should be weaned from tramadol notwithstanding documentation to the contrary indicating continued use. There is no documentation to support continued use. Based on clinical information in the medical record and the peer review evidence-based guidelines, Tramadol ER 150 mg #90 is not medically necessary.