

Case Number:	CM14-0185676		
Date Assigned:	11/13/2014	Date of Injury:	02/28/2011
Decision Date:	12/19/2014	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/07/2014

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, 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 an injury date of 02/28/11. Based on the 10/20/14 progress report provided by treating physician, the patient complains of neck pain rated 4/10 that radiates to the upper extremities and low back pain rated 8/10 that radiates to the lower extremities. Physical examination to the cervical spine revealed myospasm and tenderness to palpation to the paravertebral muscles, and range of motion limited with pain. Examination of the lumbar spine revealed myospasm and tenderness to palpation to the paravertebral muscles, and range of motion guarded and restricted on flexion and extension. Provider report dated 07/16/14 states that patient has headaches that are migrainous in nature. Patient's medications are relieving the patient's symptomatology. They are improving the patient's activities of daily living and making it possible for him to continue working. Medications were not discussed in medical records. Provider reports dated 07/16/14 and 10/20/14 state medication "refills being ordered in a separate cover letter," which was not included for review. No Request for Authorization form was included listing medications. Diagnosis 10/20/14 are: - cervicgia- lumbosacral neuritis, NOS. The utilization review determination being challenged is dated 10/21/14. Treatment reports were provided from 05/31/14 - 10/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nalfon 400mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Anti-Inflammatory Medications Page(s): 60, 61, 22.

Decision rationale: The patient presents with neck pain rated 4/10 that radiates to the upper extremities and low back pain rated 8/10 that radiates to the lower extremities. The request is for Nalfon 400mg #120. Patient's diagnosis dated 10/20/14 included cervicgia and lumbosacral neuritis. Patient's medications are relieving the patient's symptomatology. They are improving the patient's activities of daily living and making it possible for him to continue working. Regarding NSAID's, MTUS page 22 supports it for chronic low back pain, at least for short-term relief. MTUS page 60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Provider reports dated 07/16/14 and 10/20/14 state medication "refills being ordered in a separate cover letter," which was not included for review. No Request for Authorization form was included listing requested medication. In this case, review of the reports does not show documentation of functional benefit or pain reduction from Nalfon. None of the reports discuss medication efficacy or indication. There is insufficient documentation to make a decision based on guidelines. Therefore, Nalfon 400mg #120 is not medically necessary and appropriate.

Omeprazole 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 69.

Decision rationale: The patient presents with neck pain rated 4/10 that radiates to the upper extremities and low back pain rated 8/10 that radiates to the lower extremities. The request is for Omeprazole 20mg #120. Patient's medications are relieving the patient's symptomatology. They are improving the patient's activities of daily living and making it possible for him to continue working. Medications were not available in medical records. Regarding NSAIDs and GI/CV risk factors, MTUS requires determination of risk for GI events including age >65; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID. MTUS pg 69 states "NSAIDs, GI symptoms and cardiovascular risk,: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Provider reports dated 07/16/14 and 10/20/14 state medication "refills being ordered in a separate cover letter," which was not included for review. No Request for Authorization form was included listing requested medication. In this case, review of the reports does not show documentation of functional benefit from Omeprazole. There is no GI assessment to warrant PPI therapy, either. None of the reports discuss medication efficacy or indication. There is insufficient documentation to make a decision based on guidelines. Therefore, Omeprazole 20mg #120 is not medically necessary and appropriate.

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 Official Disability Guidelines, Antiemetics.

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 neck pain rated 4/10 that radiates to the upper extremities and low back pain rated 8/10 that radiates to the lower extremities. The request is for Ondansetron 8mg ODT #30. Patient's medications are relieving the patient's symptomatology. They are improving the patient's activities of daily living and making it possible for him to continue working. Medications were not available in medical records. Provider reports dated 07/16/14 and 10/20/14 state medication "refills being ordered in a separate cover letter," which was not included for review. No Request for Authorization form was included listing medications. ODG guidelines have the following regarding antiemetics: "ODG Guidelines, Pain (Chronic) chapter, Antiemetics (for opioid nausea): Not recommended for nausea and vomiting secondary to chronic opioid use." Provider reports dated 07/16/14 and 10/20/14 state medication "refills being ordered in a separate cover letter," which was not included for review. No Request for Authorization form was included listing requested medication. In this case, review of the reports does not show documentation of functional benefit from Ondansetron. None of the reports discuss medication efficacy or indication. There is no mention that patient presents with nausea or gastrointestinal complaints. Moreover, guidelines do not support this medication for nausea secondary to chronic opioid use, as provider might have intended. Therefore, Ondansetron 8mg ODT #30 is not medically necessary and appropriate. ODG guidelines have the following regarding antiemetics: "ODG Guidelines, Pain (Chronic) chapter, Antiemetics (for opioid nausea): Not recommended for nausea and vomiting secondary to chronic opioid use." Treater reports dated 07/16/14 and 10/20/14 state medication "refills being ordered in a separate cover letter," which was not included for review. No Request for Authorization form was included listing requested medication. In this case, review of the reports do not show documentation of functional benefit from Ondansetron. None of the reports discuss medication efficacy or indication. There is no mention that patient presents with nausea or gastrointestinal complaints. Moreover, guidelines do not support this medication for nausea secondary to chronic opioid use, as treater might have intended. Recommendation is for denial.

Cyclobenzaprine Hydrochloride 7.5 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

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

Decision rationale: The patient presents with neck pain rated 4/10 that radiates to the upper extremities and low back pain rated 8/10 that radiates to the lower extremities. The request is for Cyclobenzaprine Hydrochloride 7.5mg #120. Patient's medications are relieving the patient's symptomatology. They are improving the patient's activities of daily living and making it possible for him to continue working. Medications were not available in medical records. Provider reports dated 07/16/14 and 10/20/14 state medication "refills being ordered in a separate cover letter," which was not included for review. No Request for Authorization form was included listing medications. MTUS pages 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." Provider reports dated 07/16/14 and 10/20/14 state medication "refills being ordered in a separate cover letter," which was not included for review. No Request for Authorization form was included listing requested medication. In this case, review of the reports does not show documentation of functional benefit from Cyclobenzaprine HCL. None of the reports discuss medication efficacy or indication. Guidelines do not suggest use of Cyclobenzaprine for chronic use longer than 2-3 weeks. Based on the request itself, provider is requesting quantity 120, which does not indicate intended short term use. Therefore, Cyclobenzaprine Hydrochloride 7.5 mg #120 is not medically necessary and appropriate. MTUS pg 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." Treater reports dated 07/16/14 and 10/20/14 state medication "refills being ordered in a separate cover letter," which was not included for review. No Request for Authorization form was included listing requested medication. In this case, review of the reports do not show documentation of functional benefit from Cyclobenzaprine HCL. None of the reports discuss medication efficacy or indication. Guidelines do not suggest use of cyclobenzaprine for chronic use longer than 2-3 weeks. Based on the request itself, treater is requesting quantity 120, which does not indicate intended short term use. Recommendation is for denial.

Tramadol ER 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 88, 89, 76-78.

Decision rationale: The patient presents with neck pain rated 4/10 that radiates to the upper extremities and low back pain rated 8/10 that radiates to the lower extremities. The request is for Tramadol ER 150mg #90. Patient's medications are relieving the patient's symptomatology, per

provider report dated 10/20/14. MTUS Guidelines pages 88 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 4As (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. Per provider report dated 10/20/14, "medications are improving the patient's activities of daily living and making it possible for him to continue working." Provider reports dated 07/16/14 and 10/20/14 state medication "refills being ordered in a separate cover letter," which was not included for review. No Request for Authorization form was included listing requested medication. Furthermore, the four A's are not specifically addressed including discussions regarding adverse effects, aberrant drug behavior, etc. Given the lack of documentation as required by MTUS, Therefore, Tramadol ER 150mg #90 is not medically necessary and appropriate.

Sumatriptan Succinate 25mg #9 x 2 refills: 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), Triptans.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head chapter, Triptan

Decision rationale: The patient presents with neck pain rated 4/10 that radiates to the upper extremities and low back pain rated 8/10 that radiates to the lower extremities. The request is for Sumatriptan Succinate 25mg #9 x 2 refills. Patient's medications are relieving the patient's symptomatology. They are improving the patient's activities of daily living and making it possible for him to continue working. The patient presents with neck pain rated 4/10 that radiates to the upper extremities and low back pain rated 8/10 that radiates to the lower extremities. The request is for Sumatriptan Succinate 25mg #9 x 2 refills. Patient's medications are relieving the patient's symptomatology. They are improving the patient's activities of daily living and making it possible for him to continue working. ODG guidelines have the following regarding Triptans for headaches: ODG Guidelines, Head chapter, Triptan: "Recommended for migraine sufferers. At marketed doses, all oral triptans (e.g., Sumatriptan, brand name Imitrex) are effective and well tolerated." Provider states medication "refills being ordered in a separate cover letter," which was not included for review. No Request for Authorization form was included listing requested medication. In this case, review of the reports does not show documentation of functional benefit from Sumatriptan. None of the reports discuss medication efficacy or indication. Provider report dated 07/16/14 states that patient has "headaches that are migrainous in nature," however there is no actual description of migraines or efficacy of the medication prescribed. Therefore, Sumatriptan Succinate 25mg #9 x 2 refills are not medically necessary and appropriate.