MAXIMUS Federal Services

Case Number:	CM14-0210230		
Date Assigned:	01/26/2015	Date of Injury:	08/26/2013
Decision Date:	02/28/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	12/16/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 38 year old male with an injury date of 08/26/13. Based on the 08/15/14 progress report, the patient complains of sharp low back pain which radiates to his lower extremities. There is palpable paravertebral muscle tenderness with spasm, a positive seated nerve root test, a guarded/restricted standing flexion/extension, and tingling/numbness in the anterolateral thigh, anterior knee, medial left and foot all of which is in an L4 dermatomal pattern. There is also tingling/numbness in the lateral thigh, anterolateral/posterior leg, and foot. The 10/02/14 report indicates that the patient has lower back pain which radiates to the right leg and occasionally shoots down the left buttock. He has numbness, paresthesia, weakness, and swelling. Straight leg raise is positive on the right at 40 degrees, range of motion is restricted, and sensation to light touch is decreased on the right, the lateral thigh, the lateral foot, and the lateral calf. The 10/28/14 report states that the patient rates his pain as a 7/10. The patient's diagnoses include the following: Low back pain, Lumbar disc displacement, and Lumbar radiculopathy.The utilization review determination being challenged is dated 11/19/14. Treatment reports are provided from 06/20/14- 10/28/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONDANSETRON 8MG ODT 1 TAB PRN UPSET STOMACH/CAMPING/NAUSEA NO MORE THAN 2/DAY #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 (ODG) PainOndansetron (Zofran)

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 sharp low back pain which radiates to his lower extremities. The request is for Ondansetron 8 Mg ODT 1 Tab Prn Upset Stomach/ Camping/ Nausea No More Than 2/Day #30. The report with the request is not provided nor is there any indication that the patient has nausea/vomiting.The ODG guidelines have the following regarding antiemetic: ODG Guidelines, Pain (Chronic) chapter, Antiemetics (for opioid nausea): Not recommended for nausea and vomiting secondary to chronic opioid use. 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. Acute use is FDA-approved for gastroenteritis. Neither the report with the request nor the reason for the request is provided. The treater has not indicated that the patient is postoperative, undergoing chemotherapy and radiation, or has gastroenteritis, as recommended by ODG Guidelines and the FDA. The request does not meet guideline indications. The requested Ondansetron IS NOT medically necessary.

CYCLOBENZAPRINE HYDROCHLORIDE 7.5MG PO Q8H PRN PAIN ANS SPASM #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63.

Decision rationale: The patient presents with sharp low back pain which radiates to his lower extremities. The request is for Cyclobenzaprine Hydrochloride 7.5 Mg Po Q8h Prn Pain and Spasms #120. There is palpable paravertebral muscle tenderness with spasm, a positive seated nerve root test, a guarded/restricted standing flexion/extension, and tingling/numbness in the anterolateral thigh, anterior knee, medial left and foot all of which is in an L4 dermatomal pattern.The MTUS Guidelines page 63 regarding muscle relaxants also states, "Recommended non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exasperations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they showed no benefit beyond NSAIDs and pain with overall improvement. Efficacy appears to diminish over time, and prolonged use of some medication in this class may lead to dependence not recommended to be used for longer than 2 or 3 weeks. MTUS Guidelines support the usage of

Cyclobenzaprine for a short course of therapy, not longer than 2 to 3 weeks. In this case, the treater is requesting for Cyclobenzaprine Q8H #120, which is considered long-term use and not indicated by MTUS Guidelines. The requested Cyclobenzaprine IS NOT medically necessary.