

Case Number:	CM14-0210726		
Date Assigned:	12/23/2014	Date of Injury:	09/05/2012
Decision Date:	02/19/2015	UR Denial Date:	11/18/2014
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 & Rehabn

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 32-year-old female with a date of injury of 09/05/2012. According to progress report dated 07/07/2014, the patient presents with constant pain in the low back that is aggravated by bending, lifting, twisting, pulling, prolonged sitting and prolonged standing. There is radiation of pain into the lower extremities and the pain is rated as 8/10 on a pain scale. Examination of the lumbar spine revealed palpable paravertebral muscle tenderness with spasm. Seated nerve root test is positive. Range of motion is guarded and restricted. There is tingling sensation in the lateral thigh, anterolateral and posterior leg, as well as the foot. There is 4/5 strength in the EHL and ankle plantar flexors. The listed diagnosis is lumbago. The patient is to return to full duty with no limitations or restrictions. Treatment plan is for refill of medications. The patient's current medication regimen includes cyclobenzaprine, ondansetron, omeprazole and tramadol. The medical file provided for review includes progress reports from 03/03/2014 through 10/01/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine Hydrochloride Tablets 7.5 mg #120: Upheld

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

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

Decision rationale: This patient presents with chronic low back pain that radiates into the lower extremities. The current request is for Cyclobenzaprine hydrochloride tablets 7.5 mg. Request for authorization (RFA) dated 07/25/2014 notes that the requested prescription is for cyclobenzaprine hydrochloride tablets 7.5 mg, quantity 120, for pain and spasm. The MTUS Guidelines page 63 regarding muscle relaxant 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 show no benefit beyond NSAIDs in pain and overall improvement. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence." In this case, the patient has been utilizing Cyclobenzaprine for muscle relaxants as early as 04/14/2014. The MTUS Guidelines supports the use of Cyclobenzaprine for a short course of therapy, not longer than 2 to 3 weeks. The requested Cyclobenzaprine is not medically necessary.

Ondansetron ODT Tablets 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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Antiemetic under the Pain Chapter; Ondansetron (Zofran®).

Decision rationale: This patient presents with chronic low back pain that radiates into the lower extremities. The current request is for Ondansetron ODT tablets 8 mg #30. The MTUS and ACOEM Guidelines do not discuss Ondansetron. The ODG Guidelines has the following regarding Antiemetic under the Pain Chapter, ""Not recommended for nausea and vomiting secondary to chronic opioid use. It is recommended for acute use as noted below per FDA-approved indications." The ODG further states "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."It is unclear as to when this medication was first prescribed. The ODG Guidelines do not support the use of Ondansetron other than for nausea following chemotherapy, acute gastroenteritis, or for postoperative use. The patient does not meet the indication for this medication. The requested Zofran is not medically necessary.

Omeprazole Delayed-Release Capsules 20 MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular Risk Page(s): 68-69.

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

Decision rationale: This patient presents with chronic low back pain that radiates into the lower extremities. The current request is for Omeprazole Delayed-Release Capsules 20mg #120. The MTUS Guidelines page 68 and 69 states that Omeprazole is recommended with precaution for patients at risk for gastrointestinal events: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. In this case, there is no indication that the patient is taking NSAID to consider the use of omeprazole. Furthermore, the treating physician provides no discussion regarding GI issues such as gastritis, ulcers, or reflux that would require the use of this medication. The requested Omeprazole is not medically necessary.

Tramadol Hydrochloride Er 150mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

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

Decision rationale: This patient presents with chronic low back pain that radiates into the lower extremities. The current request is for tramadol hydrochloride ER 150 mg #60. For chronic opioid use, the MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." The 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. Review of the medical file indicates the patient has been prescribed tramadol for pain as early as 04/14/2014. In this case, recommendation for further use of tramadol cannot be supported as the treating physician has provided no outcome measures to denote decrease in pain, no examples of ADLs which demonstrate medication efficacy nor are there any discussions regarding specific functional improvement. Adverse side effects are not addressed and urine drug screens or CURES report are not provided as required by MTUS for opiate management. The treating physician has failed to provide the minimum requirements of documentation that are outlined in the MTUS for continued opiate use. The requested Tramadol is not medically necessary.