

Case Number:	CM15-0014494		
Date Assigned:	02/02/2015	Date of Injury:	09/07/2000
Decision Date:	03/30/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	01/26/2015

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 injured worker is a 44-year-old male who reported an injury on 09/07/2000. The mechanism of injury was not specifically stated. The current diagnoses include intervertebral thoracic disc disorder with myelopathy, intervertebral lumbar disc disorder with myelopathy, sleep disturbance and gastritis. The injured worker presented on 12/30/2014 with complaints of progressively worse low back pain and mild GI pain. The injured worker also reported worsening left shoulder pain. Upon examination, there was moderate paralumbar myospasm, moderate parathoracic myospasm, normal motor strength and intact sensation. It was noted that the injured worker was currently utilizing mirtazapine, Ambien CR, Viagra, omeprazole, gabapentin, Oxycontin, duloxetine, trazodone, ondansetron, Oxytrol, Linzess and Dilaudid. Treatment recommendations at that time included continuation of the current medication regimen. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin ER 80 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient had failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. The injured worker is currently utilizing multiple medications. There is no documentation of a failure of nonopioid analgesics prior to the initiation of an opioid. There is no documentation of objective functional improvement despite the injured worker's continuous usage of this medication since at least 07/2014. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

Ambien CR 12.5 mg #30 (1 Refill): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 2014

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. In this case, there was no documentation of a failure of nonpharmacologic treatment for insomnia prior to the initiation of Ambien CR. There is also no documentation of functional improvement despite the ongoing use of this medication. Guidelines do not recommend long term use of Ambien. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

Zofran 8 mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 2014 (pain)

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

Decision rationale: The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to chronic opioid use. It has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It has also been approved for the acute use for treatment of gastroenteritis. The injured worker does not maintain a diagnosis of gastroenteritis. The injured worker is not currently undergoing chemotherapy or radiation treatment. Therefore, the injured worker does not meet criteria for the requested medication.

There is also no frequency listed in the request. As such, the request is not medically appropriate.

Oxycontin ER 80 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient had failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. The injured worker is currently utilizing multiple medications. There is no documentation of a failure of nonopioid analgesics prior to the initiation of an opioid. There is no documentation of objective functional improvement despite the injured worker's continuous usage of this medication since at least 07/2014. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

Dilaudid 2 mg #50: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient had failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. The injured worker is currently utilizing multiple medications. There is no documentation of a failure of nonopioid analgesics prior to the initiation of an opioid. There is no documentation of objective functional improvement despite the injured worker's continuous usage of this medication since at least 07/2014. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.