

Case Number:	CM15-0112395		
Date Assigned:	06/18/2015	Date of Injury:	05/10/2012
Decision Date:	07/23/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	06/10/2015

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: New York

Certification(s)/Specialty: Anesthesiology

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 63 year old male who sustained a work related injury May 10, 2012. Past history included hypertension, hypothyroidism, L3-L5 herniated nucleus pulposus spondylolisthesis, s/p posterior lumbar interbody fusion September, 2014. According to a primary treating physician's re-evaluation and progress report, dated March 30, 2015, the injured worker presented with complaints of right sided hardware pain. There is intermittent pain in the low back on the right side, rated 4/10 and characterized as dull. There is constant pain in the right shoulder, rated 8/10, and characterized as throbbing and unchanged. He reports frequent pain in the bilateral hips, right greater than left, rated 8/10, and unchanged. Examination of the right shoulder revealed tenderness around the anterior glenohumeral region and subacromial space. Hawkins and impingement signs are positive. The lumbar spine finds a well healed midline scar and tenderness at the right lumbar paravertebral muscles. Seated nerve root test is negative and there is pain with terminal motion. There is pain and tenderness in the anterior and posterior region of the right hip and to a lesser extent on the left side and posterolateral tenderness on the left side. Diagnoses are s/p posterior lumbar interbody fusion, L3-L5; right shoulder impingement syndrome; internal derangement bilateral hips. Treatment plan included physical therapy and medication. At issue, is the request for authorization for Fenoprofen, Prevacid, Ondansetron, Cyclobenzaprine Hydrochloride, and Tramadol Hydrochloride ER.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fenoprofen (Nalfon) 400mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 21, 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Fenoprofen calcium (Nalfon) is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. According to the California MTUS Guidelines, NSAIDs reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. The ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), short-term pain relief and improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain. Current evidence-based guidelines indicate that Fenoprofen is an NSAID medication which is less effective, and has greater side effects than Naproxen or Ibuprofen. Guidelines indicate that Fenoprofen should not be used unless there is a sound medical basis for not using a safer or more effective alternative NSAID. In this case, there is no evidence of objective functional benefit from this medication. Medical necessity of the requested medication has not been established. The requested item is not medically necessary.

Prevacid (Lansoprazole DR Capsule) 30mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to CA MTUS (2009), a proton pump inhibitor, such as Prevacid (Lansoprazole), is recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. In addition, Fenoprofen was not found to be medically necessary. Based on the available information provided for review, the medical necessity for Prevacid has not been established. The requested medication 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 (ODG), Pain procedure. Mosby's Drug consult.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain and Other Medical Treatment Guidelines Medscape Internal Medicine (2014).

Decision rationale: Ondansetron (Zofran) is used to prevent nausea and vomiting that may be caused by anesthesia/surgery, or chemotherapy or radiation therapy. It is also approved for use acutely with gastroenteritis. Ondansetron is not used and is ineffective for nausea associated with narcotic analgesics. In this case, there is no documentation of ongoing complaints of nausea and vomiting. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Cyclobenzaprine Hydrochloride tablets 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 Muscle relaxants Page(s): 63.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system (CNS) depressant. It is closely related to the tricyclic antidepressants. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. The medication has its greatest effect in the first four days of treatment. It is not recommended for the long-term treatment of chronic pain. In this case, there is no documentation of functional improvement from any previous use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Tramadol Hydrochloride ER 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids.

Decision rationale: According to the California MTUS, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects.

Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. In this case, the patient has intermittent right low back pain, rated 4/10, right shoulder pain, rated 7/10 and bilateral hip pain, rated 8/10. According to the medical records, there has been no documentation of the medication's analgesic effectiveness and no clear documentation that the patient has evidence of objective functional improvement. Medical necessity for the requested medication has not been established. The requested treatment with Tramadol is not medically necessary.