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| Case Number: | CM15-0123880 | | |
| Date Assigned: | 07/08/2015 | Date of Injury: | 01/10/1982 |
| Decision Date: | 08/05/2015 | UR Denial Date: | 06/16/2015 |
| Priority: | Standard | Application Received: | 06/26/2015 |

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

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 56 year old male, who sustained an industrial injury on 1/10/1982. Diagnoses include lumbago and internal derangement knee NOS. Treatment to date has included surgical intervention (left tarsal tunnel release, undated) and conservative measures including medications, physical therapy and orthotics. Per the Primary Treating Physician's Progress Report dated 4/20/2015, the injured worker reported low back and bilateral knee pain. Physical examination of the lumbar spine revealed palpable paravertebral tenderness with spasm. Knee examination revealed tenderness in the joint line and a positive patellar grind and McMurray test. There was crepitus with range of motion. The plan of care included refill of medications and authorization was requested for Relafen, Tramadol, Prevacid and Ondansetron.

IMR ISSUES, DECISIONS AND RATIONALES

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

120 Prevacid 30mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic): Proton pump inhibitors (2015).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: 120 Prevacid 30mg is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that the patient is at risk for gastrointestinal events if they meet the following criteria (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The guidelines also state that a proton pump inhibitor can be considered if the patient has NSAID induced dyspepsia. The documentation does not indicate that the patient meets the criteria continued NSAID use and also therefore does not meet the medical necessity for a proton pump inhibitor therefore the request for Prevacid is not medically necessary.

30 Ondansetron 8mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain (Chronic): Antiemetics (for opioid nausea) (2015).

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)- Antiemetics (for opioid nausea) Ondansetron (Zofran) 1/2.

Decision rationale: 30 Ondansetron 8mg is not medically necessary per the ODG Guidelines. The MTUS does not specifically address Ondansetron (Zofran). The ODG does not recommend ondansetron (Zofran) for nausea/vomiting secondary to chronic opioid use but does recommend for acute use per FDA indications including: to chemotherapy and radiation treatment, postoperative use, or acutely used in for gastroenteritis. There is no documentation that this Ondansetron is being used postoperatively, for acute gastroenteritis, or secondary to chemo or radiation treatment therefore this medication is not medically necessary.

90 Tramadol ER 150mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

Decision rationale: 90 Tramadol ER 150mg is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state that a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The

documentation submitted does not reveal the above pain assessment or clear evidence of significant functional improvement or significant pain relief despite Tramadol. The request for continued Tramadol is not medically necessary.