

Case Number:	CM15-0170820		
Date Assigned:	09/11/2015	Date of Injury:	12/03/2001
Decision Date:	10/13/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	08/31/2015

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: Preventive Medicine, Occupational 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:

This is a 63-year-old male with a date of injury on 12-3-2001. A review of the medical records indicates that the injured worker is undergoing treatment for failed back surgery syndrome, status post lumbar spine fusion at L3-4, L4-5 and L5-S1 with painful, retained hardware. Medical records (5-7-2015 to 8-6-2015) indicate ongoing low back pain. The injured worker also complained of pain in the lower extremities. He rated his low back pain at nine out of ten. Some of the notes were hand written and difficult to decipher. Per the treating physician (8-6-2015), the employee was not working; he was temporarily very disabled. The physical exam (5-7-2015 to 8-6-2015) reveals an antalgic gait with the use of a cane. Exam of the lumbar spine revealed tenderness to the pedicle screws areas on the left and right. There was pain and spasm with lumbar motion; range of motion was reduced. The injured worker reported rashes, itching, lumps, dryness, color changes or hair and nail changes per review of systems. Straight leg raise was positive. Treatment has included surgery and medications (Norco and Ultracet since at least 5-7-2015). The request for authorization dated (8-6-2015) was for Ultracet, post-operative medications: Zofran, Duracef and Norco, Prilosec and Hydroxyzine. The original Utilization Review (UR) (8-25-2015) modified a request for Ultracet 37.5-325mg #60 with one refill to Ultracet 37.5-325mg #30. Utilization Review non-certified a request for Zofran and a request for Hydroxyzine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultracet 37.5/325mg #60 With 1 Refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter/Opioids, Specific Drug List Section.

Decision rationale: The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. Per the ODG, Ultracet is a combination of tramadol and acetaminophen. This medication is recommended for short-term use, 5 days in acute pain management. The injured worker has been taking this medication since 2014 which is not supported by the guidelines. Despite long term use there is a lack of objective documentation of functional improvement or significant decrease in pain. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Ultracet 37.5/325mg #60 with 1 refill is determined to not be medically necessary.

Zofran 8mg #10: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Society of Clinical Oncology Clinical Practice Guideline.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter/Antiemetics (for opioid nausea) Section.

Decision rationale: The MTUS Guidelines do not address the use of Zofran (Ondansetron). The ODG does not recommend the use of antiemetics for nausea and vomiting secondary to chronic opioid use. Ondansetron is FDA approved for use with nausea because of chemotherapy or radiation treatments, post-operative nausea, and acutely in gastroenteritis. There is no documentation that the injured worker suffers from any of these conditions or that the injured worker is scheduled for surgery. The request for Zofran 8mg #10 is determined to not be medically necessary.

Hydroxyzine 25mg, #60 With 1 Refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chronic pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter/Insomnia Section and Other Medical Treatment Guidelines
<http://www.medicinenet.com/hydroxyzine>.

Decision rationale: The MTUS Guidelines do not address the use of Hydroxyzine (Atarax). Per the Official Disability Guidelines, pharmacological agents should only be used for insomnia management after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically whereas secondary insomnia may be treated with pharmacological and/or psychological measures. Per manufacturer's information, Hydroxyzine is indicated for the symptomatic relief of anxiety and tension associated with psychoneurosis and as an adjunct in organic disease states in which anxiety is manifested. Also useful in the management of histamine mediated pruritis from allergic conditions such as chronic urticaria, atopic and contact dermatoses. In addition, Atarax is useful as a sedative when used as premedication and following general anesthesia. The patient's medical records do not address the timeline of the insomnia or evaluation for the causes of the insomnia. The medical records do not indicate the use of non-pharmacological modalities such as cognitive behavioral therapy or addressing sleep hygiene practices prior to utilizing a pharmacological sleep aid. Additionally, there is no indication that the injured worker suffers from pruritis or has any allergic condition that would necessitate the use of Atarax. The request for Hydroxyzine 25mg, #60 with 1 refill is determined to not be medically necessary.