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| Case Number: | CM15-0063874 | | |
| Date Assigned: | 04/09/2015 | Date of Injury: | 06/26/2011 |
| Decision Date: | 06/05/2015 | UR Denial Date: | 04/02/2015 |
| Priority: | Standard | Application Received: | 04/03/2015 |

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 35 year old male, who sustained an industrial injury on 06/26/2011. The mechanism of injury was a scuffle with a juvenile who tried to run away. Treatments to date have included back surgery, physical therapy and medications. According to a progress report dated 02/26/2015, the injured worker complained of constant pain in the low back with radiation of pain into the lower extremities with hypersensitivity of the right leg. Pain was rated 5 on a scale of 1-10. The documentation further indicated that medications were being refilled as they injured worker was taking medications as directed and they were relieving the symptomatology. It was also noted that the medications improved the injured worker's activities of daily living and made it possible for him to continue working and/or maintain activities of daily living. Diagnosis included lumbago status post posterior lumbar interbody fusion (11/14/2014). On 03/20/2015, the provider requested authorization for Fenoprofen, Omeprazole, Ondansetron, Cyclobenzaprine Hydrochloride and Tramadol ER. The documentation indicated the fenoprofen calcium was being requested for inflammation and pain, omeprazole for GI symptoms, ondansetron for headaches with cervical spine pain, cyclobenzaprine for palpable muscle spasms during examination and tramadol ER 150 mg for acute severe pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fenoprofen Calcium 400mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS
Page(s): 67.

Decision rationale: The California MTUS guidelines indicate that NSAIDS are recommended for short term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review provided documentation of objective functional improvement. However, there was a lack of documentation of an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Fenoprofen calcium 400 mg #120 is not medically necessary.

Omeprazole 20mg, #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 NSAIDS
Page(s): 69.

Decision rationale: The California MTUS guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are also for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the injured worker had GI symptoms. However, the efficacy was not provided. The request as submitted failed to indicate the frequency for the requested medication. Additionally, as the Fenoprofen is not medically necessary, the request for omeprazole would not be medically necessary. Given the above, the request for omeprazole 20 mg #120 is not medically necessary.

Ondansetron 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 Chapter, Ondansetron (Zofran).

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, Ondansetron.

Decision rationale: The Official Disability Guidelines indicate that ondansetron is recommended for postoperative pain and nausea associated with chemotherapy. It is not recommended for opioid induced nausea and vomiting. The documentation indicated the request

was made for ondansetron due to nausea associated with headaches from chronic pain. This is not one of the indications for usage of the medication per the referenced guidelines. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for ondansetron 8 mg #30 is not medically necessary.

Cyclobenzaprine Hydrochloride 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: The California MTUS guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the request was made due to palpable muscle spasms on examination. However, the efficacy of the medication was not provided and 120 tablets would exceed the guideline recommendations for duration of medication usage. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for cyclobenzaprine hydrochloride 7.5 mg #120 is not medically necessary.

Tramadol ER 150mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review provided documentation of objective functional improvement. However, there was a lack of documentation of an objective decrease in pain. There was a lack of documentation indicating the injured worker was being monitored for aberrant drug behavior. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for tramadol ER 150 mg #90 is not medically necessary.