

<b>Case Number:</b>	CM15-0063967		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	02/07/2013
<b>Decision Date:</b>	06/08/2015	<b>UR Denial Date:</b>	04/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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, Arizona  
 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 57 year old male, who sustained an industrial injury on 02/07/2013. Diagnoses include cervicgia and joint derangement shoulder status post-surgery. Treatment to date has included diagnostics, medications, activity modification and surgical intervention (shoulder). Per the Primary Treating Physician's Progress Report dated 02/19/2015, the injured worker reported sharp pain in the cervical spine with radiation into the upper extremities. There are associated headaches as well as tension between the shoulder blades. He also reported intermittent dull pain in the bilateral shoulders. Physical examination of the cervical spine revealed palpable paravertebral muscle tenderness with spasm. A positive axial loading compression test is noted. Spurling's maneuver is positive and range of motion is limited with pain. There was tingling and numbness into the lateral forearm and hand, greatest over the thumb and middle finger which correlates with a C6 and C7 dermatomal pattern. Shoulder exam revealed tenderness around the glenohumeral region and subacromial space. Rotator cuff function is intact but painful. There was reproducible symptomology with internal rotation and forward flexion. The plan of care included medications and authorization was requested for Fenoprofen calcium 400mg #120, Omeprazole 20 mg #120, Ondansetron 8mg #30, Cyclobenzaprine 7.5mg #120, Tramadol ER 150mg #90 and Sumatriptan succinate 25mg #9.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole 20mg Q12H PRN #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects; NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. As such, the request is not medically appropriate.

**Ondansetron 8mg ODT PRN #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) 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 is also FDA approved for acute gastroenteritis. The injured worker does not appear to meet criteria for the requested medication. The injured worker does not maintain a diagnosis of acute gastroenteritis. Given the above, the request is not medically necessary.

**Cyclobenzaprine hydrochloride 7.5mg Q8H PRN #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 Page(s): 63-66.

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. The injured worker has utilized the above medication since 12/2013. Despite the ongoing use of this medication, the

injured worker continues to demonstrate paravertebral muscle spasm in the cervical spine. In addition, the guidelines do not support long term use of muscle relaxants. As such, the request is not medically necessary.

**Tramadol ER 150mg QD PRN #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Opioids, specific drug list; Opioids, state medical boards guidelines.

**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 has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker has continuously utilized the above medication since at least 12/2013. There is no documentation of objective functional improvement despite the ongoing use of this medication. The injured worker continues to present with high levels of pain. The medical necessity for the ongoing use of this medication has not been established in this case. Therefore, the request is not medically appropriate at this time.

**Sumatriptan succinate 25mg #9:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Head chapter, Triptans.

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

**Decision rationale:** The Official Disability Guidelines recommend triptans for migraine sufferers. The injured worker does not maintain a diagnosis of migraine headaches. The medical necessity for the use of the above medication has not been established. There is also no frequency listed in the request. As such, the request is not medically appropriate.