

Case Number:	CM15-0096232		
Date Assigned:	05/26/2015	Date of Injury:	11/06/2010
Decision Date:	06/30/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/19/2015

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: Internal 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 36 year old female, who sustained an industrial injury on 11/06/2010. She has reported injury to the neck, left shoulder, and low back. The diagnoses have included cervicalgia; cervical/lumbar discopathy; lumbago; lumbar radiculopathy; shoulder pain; and status post left shoulder surgery. Treatment to date has included medications, diagnostics, chiropractic care, physical therapy, and surgical intervention. Medications have included Tramadol ER, Cyclobenzaprine, Nalfon, Sumatriptan succinate, and Omeprazole. A progress note from the treating physician, dated 03/23/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of constant pain in the cervical spine, with radiation of pain into the upper extremities; associated headaches that are migrainous in nature as well as tension between the shoulder blades; the pain is unchanged, and rated at a 6 on a scale of 1 to 10; constant pain in the low back, with radiation of pain into the lower extremities; the pain is unchanged, and rate a 6 on a scale of 1 to 10; constant pain in the left shoulder which is worsening and rated a 7 on a scale of 1 to 10. Objective findings included palpable cervical paravertebral muscle tenderness with spasm; a positive axial loading compression test is noted; positive Spurling's maneuver; tingling and numbness into the anterolateral shoulder and arm and lateral forearm and hand, greatest over the thumb, which correlates with a C5-C6 dermatomal pattern; an cervical spine range of motion is limited with pain; left shoulder tenderness around the anterior glenohumeral region and subacromial space; Hawkins and impingement signs are positive; palpable lumbar spine paravertebral muscle tenderness with spasm; tingling and numbness in the lateral thigh, anterolateral and posterior leg and foot, which correlates with an

L5-s1 dermatomal pattern; and range of motion of the lumbar spine is guarded and restricted. The treatment plan has included the request for Fenoprofen calcium (Nalfon) 400 mg, quantity 120; Omeprazole 20 mg, quantity 120; Ondansetron 8 mg (ODT, orally disintegrating tablet), quantity 30; Cyclobenzaprine HCl (hydrochloride) 7.5 mg, quantity 120; Tramadol ER (extended release) 150 mg, quantity 90; and Sumatriptan succinate 25 mg, quantity 9, with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fenoprofen calcium (Nalfon) 400 mg Qty 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

Decision rationale: MTUS states that Non-steroidal anti-inflammatory drugs (NSAIDs) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. There is no evidence of long-term effectiveness for pain or function. NSAIDs are recommended as a second-line treatment after acetaminophen for the treatment of acute exacerbations of chronic low back pain. The injured worker's symptoms are chronic and ongoing, without evidence of acute exacerbation or significant improvement in pain on current medication regimen. With MTUS guidelines not being met, the request for Fenoprofen calcium (Nalfon) 400 mg Qty 120 is not medically necessary.

Omeprazole 20 mg Qty 120: Upheld

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

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

Decision rationale: Proton Pump Inhibitors (PPIs) are used to treat gastrointestinal conditions such as Gastroesophageal reflux disease, Dyspepsia and Gastric ulcers, and to prevent ulcerations due to long term use of Non-steroidal anti-inflammatory drugs (NSAIDs). MTUS recommends the combination of NSAIDs and PPIs for patients at risk for gastrointestinal events, including age over 65 years of age, history of peptic ulcer, gastrointestinal bleeding, or perforation, concurrent use of ASA and high dose or multiple NSAIDs. Documentation does not support that the injured worker is at high risk of gastrointestinal events to establish the medical necessity of ongoing use of Omeprazole. The request for Omeprazole 20 mg Qty 120 is not medically necessary per MTUS guidelines.

Ondansetron 8 mg (ODT, orally disintegrating tablet) Qty 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: Pain chapter - Antiemetics (for opioid nausea).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Medications.

Decision rationale: Ondansetron (Zofran) is FDA-approved for nausea and vomiting that may be caused by chemotherapy and radiation treatment and for postoperative use. ODG states that this medication is not recommended for nausea and vomiting secondary to chronic opioid use. Documentation fails to show evidence that the injured worker's condition fits criteria for the use of Ondansetron. The request for Ondansetron 8 mg (ODT, orally disintegrating tablet) Qty 30 is not medically necessary per guidelines.

Cyclobenzaprine HCL (hydrochloride) 7.5 mg Qty 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril); Muscle relaxants (for pain) Page(s): 41; 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

Decision rationale: Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system depressant recommended as a treatment option to decrease muscle spasm in conditions such as low back pain. Per MTUS guidelines, muscle relaxants are recommended for use with caution as a second-line option for only short-term treatment of acute exacerbations in patients with chronic low back pain. The greatest effect appears to be in the first 4 days of treatment and appears to diminish over time. Prolonged use can lead to dependence. The injured worker complains of chronic neck and low back pain. Although there is noted paravertebral muscle spasm on examination at the time of the requested service, documentation fails to show significant improvement pain or functional status to justify continued use of cyclobenzaprine. The request for Cyclobenzaprine HCL (hydrochloride) 7.5 mg Qty 120 is not medically necessary per MTUS guidelines.

Tramadol ER (extended release) 150 mg Qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol Page(s): 77, 113.

Decision rationale: MTUS recommends that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented with the use of Opioids. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Tramadol is a centrally acting analgesic reported to be effective in managing neuropathic pain. Per MTUS guidelines, there are no long-term studies to allow use of Tramadol for longer than three months. The injured worker complains of chronic neck and low back pain. Documentation fails to demonstrate significant improvement in pain on current medication regimen, to support the medical necessity for the ongoing use of Tramadol ER. With MTUS guidelines not being met, the request for Tramadol ER (extended release) 150 mg Qty 90 is not medically necessary.

Sumatriptan succinate 25 mg Qty 9 with 2 refills: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Procedure Chapter, Triptans.

Decision rationale: ODG recommend Triptans for treatment of migraine headaches. Documentation provided indicates that that injured worker is being treated for Migraine and Tension headaches. Until additional medication therapy, including preventative or maintenance therapy, is instituted for this injured worker's headaches, the continued use of Sumatriptan on as needed basis is reasonable and appropriate. The request for Sumatriptan succinate 25 mg Qty 9 with 2 refills is medically necessary per guidelines.