

Case Number:	CM13-0052866		
Date Assigned:	12/30/2013	Date of Injury:	05/07/2007
Decision Date:	03/13/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	11/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 51-year-old male with date of injury of 05/07/2007. Per [REDACTED] report, 10/23/2013, listed diagnoses are: 1. Status post C6-C7 hybrid cervical reconstruction. 2. Status post left L5-S1 L&D. 3. Rule out internal derangement of right shoulder. 4. Bilateral cubital tunnel syndrome, right greater than left. On this date, the presenting chief complaint states that the patient has continued symptomatology in his upper extremities and that the patient underwent successful cervical hybrid reconstruction with majority of the radicular pain in the upper extremity resolved, but still has bilateral elbow, ulnar, and 2-digit pain consistent with cubital tunnel syndrome. Symptomatology in the patient's lumbar spine and right shoulder is essentially unchanged. Review of the reports indicates that the patient started Sumatriptan, Ondansetron, and Cyclobenzaprine in October 2012, Tramadol was started in April 2013 and Levofloxacin was started in November 2013. 10/11/2013 report by [REDACTED] reports on MRI from 2008 that showed 2- to 3-mm retrolisthesis at C5-C6, 2-mm anterolisthesis at C4-C5. There was severe right C6 foraminal stenosis and moderate on the left side. On this visit, [REDACTED] states the patient's pain without medications is a 10/10 and with medications, it drops to a 7/10.

IMR ISSUES, DECISIONS AND RATIONALES

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

Sumatriptan Succinat 25mg, #18: Upheld

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

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

Decision rationale: This employee suffers from chronic neck and low back pain with radiating symptoms to both upper extremities. It would appear that the employee has had multilevel cervical fusion as well as lumbar fusion. The employee has been under chronic pain management. Treatment under dispute is for Sumatriptan 25 mg #9 x2. The MTUS and ACOEM guidelines do not discuss triptans. The ODG guidelines are therefore consulted. It states under triptan, "recommended for migraine sufferers." Despite the review of entire progress notes from 2013, there is not a single mention of what this medication is prescribed for. There is not a mention of migraines. It would appear from review of the reports that this employee suffers from cervicogenic headaches. Triptans are not recommended for cervicogenic headaches, but for migrainous headaches. Recommendation is for denial.

Ondansetron 8mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-emetics.

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

Decision rationale: This employee presents with chronic neck and low back pain symptoms with history of multilevel cervical disk fusions and surgery of the lumbar spine. The employee has been prescribed Ondansetron since October of 2012, presumably for nausea due to polypharmacy. MTUS and ACOEM guidelines do not specifically address Ondansetron. However, the ODG guidelines indicate that it is not recommended for nausea and vomiting secondary to chronic opioid use. For antiemetics for opioid nausea, the ODG guidelines further indicate that it is not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron is recommended for acute use as noted below per FDA-approved medications. Nausea and vomiting is common with use of opioids. These side effects tend to diminish over days to weeks of continued exposure. In this employee, despite the review of progress reports in 2003 by both providers, there is not a single mention of why this medication is prescribed, what the efficacy is, and with what effect. Most importantly, the ODG guidelines do not support use of Ondansetron for nausea and vomiting secondary to chronic opioid use. Recommendation is for denial.

Cyclobenzaprine 7.5mg, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 64.

Decision rationale: This employee presents with chronic neck and low back pain with multilevel cervical fusion and surgery to lumbar spine. The treating physician has been prescribing cyclobenzaprine since October of 2012. Review of the reports showed no discussion of efficacy of this medication and the rationale under subjective or treatment discussion. However, the employee's provider provides a request for authorization report 11/19/2013 stating that cyclobenzaprine was briefly provided in the past with significant improvement of spasms

and indicates that the employee presented to his office that day with an acute exacerbation of pain and spasms and that cyclobenzaprine was appropriately prescribed for another brief course. The MTUS guidelines have specific discussion regarding Flexeril on page 64. It indicates that it is recommended for a short course of therapy. It further indicates its greatest effect appears to be in the first 4 days of treatment and that this medication is not recommended to be used for longer than 2 to 3 weeks. In this employee, the prescribed amount is #120 on a monthly basis. While the treating physician makes the argument that this is for acute exacerbation, it would appear that the employee is acutely exacerbated on a monthly basis and since October of 2012. The medication has been used on a chronic basis much longer than 2 to 3 weeks allowed by MTUS Guidelines. Recommendation is for denial.

Tramadol Hydrochloride: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88-89.

Decision rationale: This employee presents with chronic neck and low back pain with history of multilevel cervical fusion and surgery of the lumbar spine. The treating physician has been prescribing Tramadol since April of 2013. Despite the review of all of the progress reports since April 2013, there is not a specific discussion regarding efficacy of Tramadol. The treating physician does mention pain levels. For example, on 04/12/2013, treating physician documents the pain level is 8/10 with medications and 9/10 without medications; on 06/07/2013, pain level goes from 9/10 to a 7/10 with medications; on 07/05/2013, pain level is at 10/10 to a 6/10; on 08/16/2013, pain level goes from 9/10 to 6/10. None of these reports mentioned the employee's function. For the employee's functional level, the treating physician has provided Oswestry Disability Index and Neck Disability Index on 12/06/2013. Oswestry Disability Index was 76% which represents the employee perceived functional level of crippled functional disability. For Neck Disability Index, the employee rated disability at 94% which represents the employee perceiving functional level of bedbound. Despite use of these medications for 6 months, there does not appear to be any evidence that the medications are helpful. The employee still perceives his condition as bedbound and functional level at crippled. For long-term use of opiates, the MTUS guidelines pages 88 and 89 require documentation of pain and functional improvement compared to baseline. It requires pain assessment and functioning measured at 6-month intervals using a numeral scale or validated instrument. In this case, the treating physician has provided a validated instrument measurement but this measurement shows that the employee still remains crippled and bedbound without any functional improvement. One cannot tell at all that the use of Tramadol has made any difference in this employee during the course of the treatments. Recommendation is for denial.

Levofloxacin 750 mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation "Current Guidelines for Antibiotic Prophylaxis of Surgical Wounds", American Family Physician, June 1998, Woods and Dellinger.

Decision rationale: This employee presents with chronic neck and low back pain with multilevel cervical fusion and lumbar spine surgery. The treating physician has prescribed levofloxacin, an antibiotic for "routine precaution to avoid postoperative infection" according to his report 11/04/2013. This report does not mention what surgery the employee is undergoing. However, the 10/23/2013 report does indicate that the employee underwent successful cervical hybrid reconstruction. The MTUS, ACOEM, and ODG guidelines do not address postoperative antibiotic prophylaxis. American family physician article from 1998 under "current guidelines for antibiotic prophylaxis of surgical wounds" states "in general, postoperative administration is not recommended." For antibiotic prophylaxis, first dose should always be given before the procedure, preferably within 30 minutes before incision and re-administration at 1 to 2 half lives of the antibiotic is recommended for the duration of the procedure. In this case, the request is for antibiotic prophylaxis following the employee's apparent C-spine procedure. Surgical wound antibiotic is something that is provided before and immediately following the procedure by the surgeon performing the operation. In this case, the treating physician has prescribed levofloxacin several months following the employee's surgery and it does not seem to make any sense. Recommendation is for denial.