

Case Number:	CM14-0148208		
Date Assigned:	09/18/2014	Date of Injury:	05/03/2013
Decision Date:	10/22/2014	UR Denial Date:	08/18/2014
Priority:	Standard	Application Received:	09/11/2014

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. The expert reviewer is Board Certified in Internal Medicine 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 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/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:

The injured worker is a 59-year-old male who reported injury on 05/30/2013. The mechanism of injury, surgical history, prior therapies and diagnostic studies were not provided. The medications included diclofenac sodium tablets, cyclobenzaprine, Ondansetron, omeprazole and tramadol as of 04/21/2014. The documentation of 07/28/2014 revealed the injured worker had constant low back pain that was aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, prolonged standing and walking multiple blocks. The physical examination revealed the injured worker had palpable paravertebral muscle tenderness with spasms. The seated root test was positive. The injured worker had tingling and numbness in the lateral thigh, anterior and posterior leg, as well as foot in L5 and S1 dermatomal patterns. There was 4/5 strength in the EHL and ankle plantar flexors and these were L5 and S1 innervated muscles. The diagnoses included lumbago. The treatment plan included medication refills. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac Sodium ER 100mg: 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): page 67.

Decision rationale: The California MTUS Guidelines recommend NSAIDs for the short term symptomatic relief of low back pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to meet the above criteria. The duration of use was since at least 04/2014. The request, as submitted, failed to indicate the frequency and the quantity of medication being medication. Given the above, and the lack of documented objective functional improvement and an objective decrease in pain, the request for diclofenac sodium ER 100 mg is not medically necessary.y

Omeprazole DR 20mg: 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): page 69.

Decision rationale: The California MTUS Guidelines indicate that proton pump inhibitors are recommended for injured workers at intermediate or high risk for gastrointestinal events. Injured workers with no risk factor and no cardiovascular disease do not require the use of proton pump inhibitors. The clinical documentation submitted for review indicated the injured worker had utilized the medication since at least 04/2014. There was a lack of documentation of the injured worker's risk factors to support the necessity for the requested medication. Additionally, the Diclofenac was found to be not medically necessary, and as such, Omeprazole DR would not be medically necessary. The request, as submitted, failed to indicate the frequency and quantity, as well as efficacy. Given the above, the request for Omeprazole DR 20 mg is not medically necessary.

Ondansetron ODT 8mg: 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 Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Pain Chapter, Ondansetron

Decision rationale: The Official Disability Guidelines indicate that Ondansetron is not recommended for opioid induced nausea and vomiting. The clinical documentation submitted for review failed to provide a documented rationale for the requested medication. The duration of use was noted to be since at least 04/2014. The request, as submitted, failed to indicate the frequency and quantity of the medication being requested. Given the above, the request for Ondansetron ODT 8 mg is not medically necessary.

Cyclobenzaprine 7.5mg: 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 Manual Therapy, Page(s): page 58, 59.

Decision rationale: The California MTUS Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had utilized the medication since at least 04/2014. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request, as submitted, failed to indicate the frequency and quantity of medication being requested. Given the above, the request for cyclobenzaprine 7.5 mg is not medically necessary.

Tramadol HCL ER 150mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids.

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

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement and objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to meet the above criteria. The request, as submitted, failed to indicate the frequency for the requested medication, as well as the quantity. Additionally, the medication was noted to be utilized since at least 04/2014. Given the above, the request for tramadol hydrochloride ER 150 mg is not medically necessary.