

Case Number:	CM15-0127471		
Date Assigned:	07/30/2015	Date of Injury:	09/30/2007
Decision Date:	10/22/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	06/30/2015

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: Pediatrics, 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 52 year old male who sustained an industrial injury on 09-30-2007. According to a progress report dated 03-10-2015, the injured worker reported significant dysphagia and hardware related pain in his neck. Neck pain was rated 6 on a scale of 1-10. He reported increased difficulty with sleep due to pain. There was difficulty swallowing. Pain was unchanged. He also report persistent pain in his lower back. The previously requested surgery to his lumbar spine had been authorized. Low back pain was rated 6. There was radiation of pain into the lower extremities. Recommendations included C4 through C6 removal of the cervical spinal hardware with inspection of fusion mass. The provider noted that no conservative measures could result in improvement of these symptoms. The injured worker had been experiencing her symptoms for several months and had not found any benefit from the medication she had been provided nor the injections administered over top of the hardware. Medications were requested under a separate cover letter. On 04-04-2015, the provider requested authorization for Fenoprofen Calcium, Omeprazole, Ondansetron, Cyclobenzaprine, Tramadol and Sumatriptan Succinate. According to the most recent progress report submitted for review and dated 04-28-2015, the injured worker reported constant pain in the cervical spine with hardware-related pain and dysphagia. Pain was characterized as sharp. There was no real radiation of pain into the upper extremities. There was difficulty swallowing. There was increased difficulty with sleep due to pain. Pain was rated 6 on a scale of 1-10 and was unchanged. He reported constant pain in the low back that was characterized as sharp. There was radiation of pain into the lower extremities. Pain was rated 8. Review of systems was unchanged from an initial report. Diagnoses included status post C5 to C7 anterior cervical discectomy and fusion 06-15-2012, retained symptomatic hardware cervical spine, thoracic

spine discopathy, lumbar spine discopathy, electrodiagnostic evidence of bilateral carpal tunnel syndrome and depression. The injured worker was awaiting removal of the symptomatic cervical spine hardware. The provider noted that the injured worker could take the appropriate pharmacological agents for symptomatic relief. Medications were being requested under a separate cover letter. The injured worker was retired. The progress report did not list current medications regimen. On 06-09-2015, the provider requested authorization for Nabumetone (Relafen) 750 mg #120, Lansoprazole (Prevacid) Delayed Release 30 mg #120, Ondansetron 8 mg #30, Cyclobenzaprine Hydrochloride 7.5 mg #120, Tramadol ER 150 mg #90 and Sumatriptan Succinate 25 mg #9 with 1 refill (1x2) which is being reviewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nabumetone (Relafen) 750mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, specific drug list & adverse effects, NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. CA MTUS Chronic Pain Medical Treatment Guidelines state that NSAIDS (nonsteroidal anti-inflammatory drugs) are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. MTUS specific recommendations for NSAIDs include treatment of osteoarthritis for the shortest time possible and short term treatment of back pain. It may be useful for breakthrough and mixed pain conditions in patients with neuropathic pain. Other chronic pain conditions are not discussed. Guidelines recommend NSAIDS for acute exacerbations of chronic back pain as a second-line treatment after acetaminophen. In this case, there is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care. Medical necessity for the requested treatment is not established. The requested treatment is not medically necessary.

Lansoprazole (Prevacid) Delayed Release 30mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: According to CA MTUS (2009), a Proton Pump Inhibitor, such as Prevacid (Lansoprazole), is recommended for patients taking NSAIDs (nonsteroidal anti-inflammatory drugs) with documented GI (gastrointestinal) distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. In this case, records show that the injured worker had been prescribed a proton pump inhibitor due to a history of some epigastric pain and stomach upset while using nonsteroidal anti-inflammatory medications in the past for chronic pain. Since the request for Nabumetone was found to be not medically necessary, medical necessity for the requested treatment (Lansoprazole) is not established. The requested treatment 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 ODG-TWC Pain.

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-Antiemetics, Ondansetron.

Decision rationale: Ondansetron (Zofran) is used to prevent nausea and vomiting that may be caused by anesthesia, surgery, or chemotherapy or radiation therapy. It is also approved for use acutely with gastroenteritis. Ondansetron is not used and is ineffective for nausea associated with narcotic analgesics. In this case, the injured worker was prescribed Ondansetron for nausea associated with the headaches that were present with chronic cervical spine pain. Guidelines do not recommend Ondansetron for this indication. In addition, there was no discussion of treatment efficacy with use of Ondansetron. Medical necessity for the requested treatment is not established. The requested treatment is not medically necessary.

Cyclobenzaprine Hydrochloride 7.5mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. CA MTUS Chronic Pain Medical Treatment Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and

muscle tension and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs (nonsteroidal anti-inflammatory drugs) in pain and overall improvement. Also there was no additional benefit shown in combination with NSAIDs. Efficacy appeared to diminish over time and prolonged use of some medications in this class may lead to dependence. Per MTUS guidelines, Cyclobenzaprine is not recommended to be used longer than 2-3 weeks. In this case, the physical examination demonstrated muscle spasms despite use of Cyclobenzaprine. There was no indication that the injured worker was being treated for an acute exacerbation of chronic pain. In addition, there is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care. Medical necessity for the requested treatment is not established. The requested treatment is not medically necessary.

Tramadol ER 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids, dosing, Opioids, specific drug list.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Chronic Pain Medical Treatment Guidelines state that on-going management of opioid therapy should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain, the least reported pain over the period since the last assessment, average pain, the intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Information from family members or other caregivers should be considered in determining the patient's response to treatment. In addition to pain relief, the practitioner should monitor side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. In this case, the treating provider did not document the least reported pain over the period since the last assessment, average pain, the intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Despite use of Tramadol, pain levels remained unchanged. In addition, there is a lack of functional improvement with the treatment already provided. The treating provider did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care. Medical necessity for the requested treatment is not established. The requested treatment is not medically necessary.

Sumatriptan Succinate 25mg #9 with 1 refill (1x2): Upheld

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

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: CA MTUS Chronic Pain Medical Treatment Guidelines state that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Official Disability Guidelines state that Triptans are recommended for migraine sufferers. At marketed doses, all oral triptans (e.g., sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients. A poor response to one triptan does not predict a poor response to other agents in that class. In this case, Sumatriptan Succinate was prescribed to the injured worker for migrainous headache that was associated with cervical spine pain. There is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care. Medical necessity for the requested treatment is not established. The requested treatment is not medically necessary.