MAXIMUS Federal Services

Case Number:	CM13-0016272		
Date Assigned:	11/06/2013	Date of Injury:	05/25/2012
Decision Date:	02/28/2014	UR Denial Date:	08/15/2013
Priority:	Standard	Application Received:	08/26/2013

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 Orthopedic Surgery, and Sports 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 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:

The patient is a 62-year-old injured worker who reported an injury on 05/25/2012. The mechanism of injury was not provided for review. The patient developed chronic low back pain radiating to the bilateral lower extremities. The patient was treated with injections, physical therapy, a home exercise program, and medications. The patient's most recent clinical examination findings included tenderness to palpation in the lumbar area with disturbed sensation in the L5-S1 dermatomes. The patient's diagnoses included lumbar discopathy. The patient's treatment plan included continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrochloride ER mg, quantity 90, 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Initiating Therapy Page(s): 77.

Decision rationale: The California Medical Treatment Utilization Schedule recommends the initiation of opioid usage be supported by an initial urine drug screen, documentation of a pain contract, and an assessment of risk factors associated with opioid dependence. The clinical

documentation submitted for review does provide evidence that the patient submitted to a urine drug screen with appropriate results prior to initiation of opioid therapy. However, the clinical documentation does not address a pain contract or a risk assessment for opioid dependence. The request for Tramadol Hydrochloride ER mg, quantity 90 is not medically necessary and appropriate.

Medrox Patch, quantity 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The California Medical Treatment Utilization Schedule does not recommend the use of topical analgesics as they are largely experimental and not supported by scientific evidence. This formulation of Medrox contains methyl salicylate, menthol, and capsaicin. Additionally, the California Medical Treatment Utilization Schedule does recommend the use methyl salicylate and menthol in the treatment of osteoarthritic pain. However, the clinical documentation submitted for review does not provide any evidence that the patient's pain is related to osteoarthritis. Additionally, this formulation contains Capsaicin. California Medical Treatment Utilization Schedule does not recommend Capsaicin as a topical agent unless the patient has failed to respond to other first line treatments, including other oral analgesics. There was no evidence within the documentation that the patient has failed to respond to first line treatments, including other oral analgesics. The request for Medrox Patch, quantity 30 is not medically necessary and appropriate.

Cyclobenzaprine Hydrochloride Tablets 7.5 mg, quantity 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (FlexerilÂ®) Page(s): 23.

Decision rationale: The California Medical Treatment Utilization Schedule recommends cyclobenzaprine, or Flexeril, for short courses of treatment to provide pain relief for acute exacerbations of a patient's chronic pain. The clinical documentation does provide evidence that the patient has pain that would benefit from this type of medication. However, the clinical documentation does provide evidence that the patient was previously prescribed this medication for a total of 120 tablets and the UR modified the request for a partial certification for this medication, quantity 20. In this case, the request exceeds guideline recommendations as it does not support recommendation for chronic use. The request for Cyclobenzaprine Hydrochloride Tablets 7.5 mg, quantity 120 are not medically necessary and appropriate.

Ondansetron ODT Tablets 4mg, quantity 30, 2 refills: 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).

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, Anti-Emetics.

Decision rationale: The Official Disability Guidelines (ODG) do not recommend the use of anti-emetics for gastrointestinal symptoms to include nausea and vomiting related to medication usage. This medication is primarily prescribed for postsurgical symptoms and symptoms related to cancer treatments. It is also frequently prescribed for acute gastritis. The clinical documentation submitted for review does not provide any evidence that the patient suffers from acute gastritis. The most recent evaluation does not provide an adequate assessment of the patient's gastrointestinal system to support symptoms that would benefit from the use of this medication. The request for Ondansetron ODT Tablets 4mg, quantity 30, 2 refills, is not medically necessary and appropriate.