

Case Number:	CM13-0048595		
Date Assigned:	12/27/2013	Date of Injury:	06/01/2002
Decision Date:	03/11/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/06/2013

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 and Rehabilitation, has a subspecialty in Pediatric Rehabilitation Medicine and is licensed to practice in Texas. 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 55-year-old male who reported an injury on 06/01/2002. The mechanism of injury was not provided for review. The patient's most recent clinical evaluation revealed that the patient had chronic symptomatology of the right knee and low back. Physical examination revealed there was no change in symptoms reported to be tenderness to palpation over the distal lumbar segments with range of motion limited due to pain and a positive straight leg raising test bilaterally with dysesthesia at the L5 and S1 dermatomes. Physical examination of the knee noted that symptoms remained unchanged with tenderness at the right greater than the left knee joint line with a positive McMurray's sign bilaterally, a positive patellar compression test bilaterally and pain with range of motion. The patient's diagnoses included lumbar discopathy and internal derangement of the bilateral knees. The patient's medications included Naprosyn, cyclobenzaprine, ondansetron, omeprazole, quazepam, tramadol, and Terocin patches. The patient's treatment plan was to continue medications. The patient was regularly monitored for medication compliance with urine drug screens.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550 mg #100: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Section, Pages 60 and 68. Page(s): 60, 68.

Decision rationale: The requested naproxen 550 mg #100 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule recommends the use of medications in the management of a patient's chronic pain be supported by documentation of pain relief and functional benefit. The clinical documentation submitted for review does indicate that the patient's presentation has remained unchanged with the current medication schedule. However, there is no quantitative assessment of pain relief or functional benefit related to medication usage. As such, the requested naproxen 500 mg #100 is not medically necessary or appropriate.

Cyclobenzaprine HCL 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 Muscle Relaxants Page(s): 63.

Decision rationale: The requested cyclobenzaprine HCL 7.5 mg #120 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule only recommends muscle relaxants for short courses of treatment of up to 2 to 3 weeks. As the patient has been on this medication for longer than 2 to 3 weeks, continuation would not be supported. Additionally, the clinical documentation lacks any evidence of functional benefit or pain relief as a result of medication usage. Therefore, cyclobenzaprine HCL 7.5 mg #120 is not medically necessary or appropriate.

Ondansetron ODT 8mg #30 x3 QTY 60: Upheld

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

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 requested ondansetron ODT 8 mg #30 x3 QTY 60 is not medically necessary or appropriate. Official Disability Guidelines recommend this medication for patients undergoing cancer treatment, to manage postoperative nausea and vomiting, and for instances of acute gastritis. The clinical documentation submitted for review did not provide any evidence that the patient had acute gastritis, was being treated for cancer, or had recently undergone any surgical interventions that required postsurgical treatment. The clinical documentation submitted

for review did not provide an adequate assessment of the patient's gastrointestinal system to support the use of this type of medication. As such, the requested ondansetron ODT 8 mg #30 x3 QTY 60 is not medically necessary or appropriate.

Omeprazole delayed release 20 mg #120: Upheld

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

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

Decision rationale: The requested omeprazole delayed release 20 mg #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of this type of medication for patients who are at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support that the patient is at risk for developing gastrointestinal symptoms related to medication usage. Therefore, continued use would not be indicated. As such, the requested omeprazole delayed release 20 mg #120 is not medically necessary or appropriate.

Quazepam 15mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 34.

Decision rationale: The requested Quazepam 15 mg #30 is not medically necessary or appropriate. The clinical documentation submitted for review indicates that the patient has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule only recommends the use of benzodiazepines for short courses of treatment. As this patient has been on this medication for an extended duration, continued use would not be indicated. Additionally, there is no documentation of functional benefit or symptom relief to support use of this medication. As such, the requested Quazepam 15 mg #30 is not medically necessary or appropriate.

Tramadol HCL ER 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Topical Analgesics Page(s): 60, 111.

Decision rationale: The requested Terocin patch Qty 10 is not medically necessary or appropriate. This medication contains components to include methyl salicylate, menthol, capsaicin, and lidocaine. California Medical Treatment Utilization Schedule does recommend the use of lidocaine in a patch form, methyl salicylate and menthol for pain relief. However, capsaicin is only recommended as a topical agent for patients who have failed to respond to other treatments. The clinical documentation submitted for review does not adequately address other treatments to support the use of capsaicin as a topical analgesic. Additionally, this medication is not supported by functional benefit or symptom relief. Therefore, continued use would not be indicated. As such, the requested Terocin patch Qty 10 is not medically necessary or appropriate.