

Case Number:	CM13-0052762		
Date Assigned:	12/30/2013	Date of Injury:	05/30/2010
Decision Date:	03/14/2014	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 Internal Medicine and Medical Oncology 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 54-year-old male who reported an injury on 05/29/2010. The patient was reportedly stepping out of his work van when he felt pain in the lower back and lower extremities followed by left knee buckling. The patient is diagnosed with lumbar discopathy, internal derangement of the left knee, and status post right knee arthroscopy. The patient was seen by [REDACTED] on 06/18/2013. The patient reported significant improvement in symptomatology following a right knee arthroscopy. The patient also reported chronic lower back pain and left knee pain. Physical examination revealed tenderness to palpation of the lumbar spine, paravertebral muscle spasm, positive straight leg raising, dysesthesia in the L5 and S1 dermatomes, diminished strength, and tenderness to palpation of the joint line in the left knee with positive McMurray's testing and compression testing. Treatment recommendations included a series of Synvisc injections into the right knee, a lumbar interbody fusion and continuation of current medications including naproxen, Cyclobenzaprine, Ondansetron, Omeprazole, Medrox pain relief ointment, and tramadol ER.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen sodium 550mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. As per the documentation submitted, the patient had continuously utilized this medication. The patient reported only temporary relief following the use of naproxen. There is no evidence of satisfactory response to treatment. Additionally, California MTUS Guidelines state there is no evidence of long-term effectiveness for pain or function. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

Cyclobenzaprine 7.5mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. The patient's physical examination continues to reveal paravertebral muscle spasms. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

Ondansetron 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG

Decision rationale: Official Disability Guidelines state Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment and has been approved for postoperative use. The patient does not meet criteria for the requested medication. Therefore, the request is non-certified.

Quazepam 15mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24..

Decision rationale: California MTUS Guidelines state benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. As per the documentation submitted, the patient does not report anxiety or depressive symptoms. The medical necessity for the requested medication has not been established. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

Tramadol ER 150mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. Satisfactory response to treatment has not been indicated. Therefore, the request is non-certified.

Levofloxacin 750mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine.

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

Decision rationale: Official Disability Guidelines state Levaquin is recommended as first line treatment for osteomyelitis, chronic bronchitis, and pneumonia. The patient does not maintain any of the abovementioned diagnoses. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.