

Case Number:	CM14-0106109		
Date Assigned:	09/24/2014	Date of Injury:	09/07/2012
Decision Date:	10/24/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	07/09/2014

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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 51-year-old male who reported an injury on 09/07/2012 after quickly turning his patrol car. The injured worker reportedly sustained an injury to his low back. The injured worker's treatment history included chiropractic care, physical therapy, multiple medications, and epidural steroid injections. The injured worker's diagnostic studies included x-rays, MRIs, and electrodiagnostic studies. The injured worker was evaluated on 07/11/2014. It was documented that the injured worker had continued low back pain. Physical findings included tenderness to palpation at the paravertebral musculature with a positive straight leg raising test and normal motor strength weakness. The injured worker's treatment plan included continued medications, continued acupuncture, and continued chiropractic care. The injured worker's diagnoses included internal left knee derangement, and severe lumbar discopathy. No request for authorization was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine HCL 7.5MG #120: Upheld

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

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

Decision rationale: The requested Cyclobenzaprine HCL 7.5MG #120 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not support the use of muscle relaxants in the management of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 10/2012. The clinical documentation submitted for review does not provide any evidence of significant efficacy or functional increases to support continued use. Also the injured worker has been taking this medication for a duration that exceeds guideline recommendations. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Cyclobenzaprine HCL 7.5MG #120 is medically necessary or appropriate.

Tramadol 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Tramadol 150mg #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, documented functional benefit, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence of significant functional benefit or pain relief as a result of the use of this medication. The clinical documentation indicates that the injured worker has been taking this medication for an extended duration of time. However, the clinical documentation also indicates that the injured worker is monitored for aberrant behavior. However, in the absence of documentation of efficacy, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Tramadol 150mg #90 is not medically necessary or appropriate.

Ondansetron ODT 8mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines TWC Pain Procedure

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain chapter, Anti-emetics

Decision rationale: The requested Ondansetron ODT 8mg #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this

medication. Official Disability Guidelines do not recommend antiemetics to address side effects of opioid usage. The clinical documentation submitted for review does not provide any evidence of acute gastritis. Therefore, ongoing use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ondansetron ODT 8mg #60 is not medically necessary or appropriate.

Medrox Pain Relief Ointment 120g x2: Upheld

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

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

Decision rationale: The requested Medrox Pain Relief Ointment 120g x2 is not medically necessary or appropriate. The requested medication is a compounded medication that contains menthol, methyl salicylate, Lidocaine, and Capsaicin. The California Medical Treatment Utilization Schedule does not recommend the use of Capsaicin in the absence of failure to respond to all first line medications to include antidepressants and anticonvulsants. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to first line medications. Additionally, the California Medical Treatment Utilization Schedule does not recommend the use of Lidocaine in a cream or gel formulation as it is not FDA approved to treat neuropathic pain. The California Medical Treatment Utilization Schedule states that any medication that contains at least 1 drug or drug class that is not recommended is not recommended. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not clearly identify an applicable body part or duration of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Medrox Pain Relief Ointment 120g x2 is not medically necessary or appropriate.