MAXIMUS Federal Services

Case Number:	CM14-0109686		
Date Assigned:	08/01/2014	Date of Injury:	08/23/2012
Decision Date:	12/19/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	07/15/2014

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 Occupational 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 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 male with date of injury 8/23/2012. Per primary treating physician's progress note dated 6/2/2014, the injured worker complains of intermittent pain in the right knee that is aggravated by squatting, kneeling, ascending and descending stairs, walking multiple blocks, and prolonged standing. He admits to some swelling and buckling. The pain is characterized as dull, and is mproving. He rates the pain at 5/10. He also reports intermittent pain in the low back that is aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, prolonged standing, and walking multiple blocks. Pain is characterized as sharp with radiation into the lower extremities. His pain is unchanged and rated at 6/10. The injured worker remains off work. On examination of the lowe back there is palpable paravertebral muscle tenderness with spasm. Seated nerve root test is positive. Standing flexion and extension are guarded and restricted. There is no clinical evidence of stability on exam. Coordination and balance are intact. Sensation and strength are intack. The right knee has tenderness in the joint line. Patellar grind test is positive. Anterior drawer test and posterior pivot shift test are negative. McMurray is positive. There is crepitus with painful range of motion. There is no clinical evidence of instability. Diagnosis is knee pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dicofenac sodium (voltaren SR) 100MG # 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs section Page(s): 67-71.

Decision rationale: The use of NSAIDs are recommended by the MTUS Guidelines with precautions. NSAIDs are recommended to be used secondary to acetaminophen, and at the lowest dose possible for the shortest period in the treatment of acute pain or acute exacerbation of chronic pain as there are risks associated with NSAIDs and the use of NSAIDs may inhibit the healing process. The injured worker has chronic injuries with no change in pain level and no acute injuries reported. The requesting physician explains that Voltaren SR 100 mg is prescribed for inflammation and pain. The injured worker is reported to have improving knee pain. He is chronically injured without an acute exacerbation. Chronic use of NSAIDs is not recommended by the MTUS Guidelines.The request for Dicofenac sodium (voltaren SR) 100MG # 120 is determined to not be medically necessary.

Omeprozole 20mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk section Page(s): 68-69.

Decision rationale: Proton pump inhibitors, such as Prilosec are recommended by the MTUS Guidelines when using NSAIDs if there is a risk for gastrointestinal events. The claims administrator reports that utlzation review dated 2/10/2014 had non-certified a request for Omeprazole delayed release 20 mg #120 mg. This request is not accompanied with any information regarding gastrointestinal complaints or increased risk factors for gastrointestinal events with the use of NSAIDs. The request for Omeprozole 20mg #120 is determined to not be medically necessary.

Ondansetron 8mg ODT # 30 X2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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, Antiemetics (for opioid nausea)

Decision rationale: The MTUS Guidelines do not address the use of ondansetron. The ODG does not recommend the use of antiemetics for nausea and vomiting secondary to chronic opioid use. Ondansetron is FDA approved for use with nausea as a result of chemotherapy or radiation

treatments, post-operative nausea, and acutely in gastroenteritis.The request for Ondansetron 8mg ODT # 30 X2 is determined to not be medically necessary.

Orphenadrine Citrate ER 100MG # 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) section, Weaning of Medications section Page(s): 63-65, and 124.

Decision rationale: Non-sedating muscle relaxants (for pain) are recommended by the MTUS Guidelines with caution for short periods for treatment of acute exacerbations of chronic low back pain, but not for chronic or extended use. In most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Orphenadrine is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. The claims administrator reports that a request for cyclobenzaprine 7.5 mg #120 had been non-certified on 2/10/2014. Chronic use of muscle relaxants is not recommended by the MTUS Guidelines.The request for Orphenadrine Citrate ER 100MG # 120 is determined to not be medically necessary.

Tramadol Hydrochloride ER 150MG # 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, Weaning of Medications section Page(s): 74-95 and 124.

Decision rationale: Tramadol is a central acting synthetic opioid that exhibits opioid activity with a mechanism of action tht inhibits the reuptake of serotonin and norepinephrine with side effects similar to traditional opioids. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam.The injured worker has improved pain in his right knee and unchanged pain in his low back. Both the right knee and low back pain are rated at 5/10. The medical reports do not indicate any objective or subjective functional improvement with the use of Tramadol, or reduction in pain severity. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines.It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawl symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to

continue treatment.The request for Tramadol Hydrochloride ER 150MG # 90 is determined to not be medically necessary.