

Case Number:	CM14-0017855		
Date Assigned:	04/30/2014	Date of Injury:	03/09/2012
Decision Date:	07/09/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	02/12/2014

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 Physical Medicine and Rehabilitation, 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 51-year-old who reported an injury on 01/15/1999. The mechanism of injury was not provided in the clinical documentation submitted. Within the clinical note dated 12/04/2013, the injured worker complained of pain to her right knee. She reported having right knee surgery. The date was not provided. On the physical examination, the provider noted right knee revealed swelling and some pain in anterior joint line space. The examination of the right foot was essentially unchanged. There was tenderness at the right anterior lateral aspect of the foot along with pain with terminal motion. The diagnoses included status post right 5th metatarsal fracture, right ankle and foot sprain with plantar fasciitis. Prior treatment consisted of the injured worker had an intra-articular injection to the right knee on 12/04/2013. The provider requested Cyclobenzaprine Hydrochloride 7.5 mg #120, and Ondansetron ODT 8 mg #60 for symptomatic relief of pain. The request for authorization form was not provided in the clinical documentation submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLONBENZAPRINE HYDROCHLORIDE 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 Relaxant Page(s): 63, 64.

Decision rationale: The request for Cyclobenzaprine Hydrochloride 7.5 mg #120 is non-certified. The injured worker complained of right knee pain. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The Guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases they show no benefit beyond the NSAIDs in pain and overall improvement. Also, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, along with the use of medications in this class may lead to dependence. There is lack of objective indicating the injured worker to have muscle spasms. The injured worker had been utilizing the medication for an extended period of time, since at least 12/2013 which exceeds the Guidelines recommendations of short term use of 2 to 3 weeks. The request as submitted failed to provide the frequency of the medication. Therefore, the request for Cyclobenzaprine Hydrochloride 7.5 mg #120 is not medically necessary and 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 (ODG) Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Antiemetics.

Decision rationale: The request for Ondansetron ODT 8 mg #60 is non-certified. The injured worker complained of right knee pain. The Official Disability Guidelines do not recommend Ondansetron, a form of antiemetics for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is a common use with opioids. The side effect tends to diminish over days to weeks of continued exposure. Study of opioid adverse effects including nausea and vomiting are limited to short term duration, less than 4 weeks, and have limited application to long term use. If nausea and vomiting remain prolonged, other etiologies of these symptoms should be evaluated for. There is lack of documentation indicating the injured worker to have nausea and vomiting. The request as submitted failed to provide the frequency of the medication. There was also a lack of efficacy documented to support continuation. Therefore, the request for ondansetron ODT 8 mg #60 is not medically necessary and appropriate.