

Case Number:	CM14-0118041		
Date Assigned:	08/06/2014	Date of Injury:	03/14/2013
Decision Date:	10/03/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/28/2014

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 & Rehabilitation, has a subspecialty in Pain 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 45 year old male who reported an injury on 03/14/2013; the mechanism of injury was not indicated. The injured worker had diagnoses including lumbago and knee pain. Prior treatments included Physical therapy 8 visits and knee bracing. Diagnostic studies included an MRI of the left knee and an X-ray of the chest on 02/17/2014. The injured worker's surgical history was not provided in the medical records. The clinical note dated 06/10/2014 noted the injured worker complained of constant pain in the left knee, the low back pain, and some swelling and buckling. He rated his pain 5/10 and reported radiation of pain into the lower extremities. There was tenderness in the joint line. The injured worker reported knee pain aggravated by squatting, kneeling, ascending and descending stairs, walking blocks, and prolonged standing. Standing flexion and extension were guarded and restricted. The physician noted the injured worker pain was improving. Medications included naproxen sodium, Norflex, Tramadol, and Ondansetron. The treatment plan included a request for Ondansetron 8 mg ODT, #30, Orphenadrine Citrate #120, and Orphenadrine Citrate #120. The rationale for the request was to lessen his pain, nausea and vomiting, and improve his function particularly range of motion of the left knee and the lower back. The request for authorization were provided within the medical records dated 06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ondansetron 8 mg ODT, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic), Antiemetics (for opioid nausea).

Decision rationale: The Official Disability Guidelines note antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. If nausea and vomiting remains prolonged, other etiologies of these symptoms should be evaluated for. Zofran is recommended for nausea and vomiting secondary to chemotherapy and radiation treatment, as well as acute use for gastroenteritis. There is no indication that the injured worker is experiencing symptoms of nausea or vomiting for which the medication would be recommended. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, the request failed to provide the frequency of symptoms to support Ondansetron to be utilized. Therefore, the request for Ondansetron 8 mg ODT, #30 is not medically necessary.

Orphenadrine Citrate #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain

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

Decision rationale: The injured complained of constant pain in the left knee, the low back pain, and some swelling and buckling. The California MTUS guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. 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 NSAIDs in pain and overall improvement. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The requesting physician's rationale for the request is not indicated within the provided documentation. There is a lack of documentation demonstrating how long the injured worker has been utilizing the medication. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore the request for Orphenadrine Citrate #120 is not medically necessary.

Tramadol ER 150 mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Page(s): 78.

Decision rationale: The California MTUS guidelines recommend continuing review with documentation of pain relief, functional status, appropriate medication use, and side effects. The patient pain assessment must include, current pain, the last reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Acceptable reply to treatment plan must be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore the request for Tramadol ER 150 mg, #90 is not medically necessary.