

Case Number:	CM14-0124970		
Date Assigned:	08/11/2014	Date of Injury:	05/13/2004
Decision Date:	12/12/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/07/2014

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 Interventional Spine 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 patient is a 53-year-old male with a date of injury of 05/13/2004. The listed diagnoses per [REDACTED] are: 1. Lumbosacral neuritis, NOS. 2. Internal derangement knee, NOS. The medical file provided for review includes 1 progress report. According to progress report on 07/08/2014, the patient presents with constant right knee pain and low back pain. Examination of the lumbar spine revealed palpable vertebral muscle tenderness with spasm. Seated nerve root test is positive. Range of motion is decreased. Examination of the knee revealed tenderness in the joint line and patella grind test is positive. Under treatment plan, it notes "medications refill is being ordered under separate cover letter." This is a request for refill of medications. Utilization review denied the request on 07/31/2014. The medical file provided for review includes 1 treatment report from 07/08/2014

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac sodium ER 100mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 60, 61, 22.

Decision rationale: This patient presents with constant right knee and low back pain. "Utilization review from 07/28/2014 states that this is a request for diclofenac sodium #120. The MTUS Guidelines page 22 supports the use of NSAID for chronic low back pain and as a first line of treatment. In this case, the treater requests a refill of medications on 07/08/2014, but does not provide any discussion regarding medication efficacy. MTUS page 60 requires documentation of pain assessment and functional changes when medications are used for chronic pain. Given the lack of discussion regarding efficacy, continuation of diclofenac sodium cannot be supported. The request is not medically necessary.

Omeprazole 20mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: This patient presents with constant right knee and low back pain. The treater is requesting a refill of Omeprazole 20 mg #120. The MTUS Guidelines page 68 and 69 states that Omeprazole is recommended with precaution for patients at risk for gastrointestinal events: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. The patient has been taking NSAID on a long term basis, but the treater does not document dyspepsia or GI issues. Routine prophylactic use of PPI without documentation of gastric issues is not supported by the guidelines without GI-risk assessment. The request is not medically necessary.

Ondansetron 8mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. 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 has the following regarding antiemetic

Decision rationale: This patient presents with constant right knee and low back pain. The treater is requesting a refill of ondansetron 8 mg #30. The MTUS and ACOEM Guidelines do not discuss Zofran; however, ODG Guidelines under its pain chapter has the following regarding antiemetic, "not recommended for nausea and vomiting secondary to chronic opiate use. Recommended for acute use as noted below for FDA-approved indications. Ondansetron (Zofran), this drug is a serotonin 5-HT₃ receptor antagonist. It is FDA approved for nausea and vomiting secondary to chemo and radiation treatment. It is also FDA approved for postoperative use." In this case, there is no rationale indicating why this medication is prescribed. The ODG

Guidelines do not support the use of ondansetron other than postoperative use. Given there is no indication of recent surgery, the request is not medically necessary.

Cyclobenzaprine 7.5mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63,64.

Decision rationale: This patient presents with constant right knee and low back pain. The treater is requesting a refill of cyclobenzaprine 7.5 mg #120. The MTUS Guidelines page 64 states, "Cyclobenzaprine is recommended for short course of therapy. Limited mixed evidence does not allow for recommendation for chronic use." In this case, the treater is requesting a refill of cyclobenzaprine 7.5 mg #120. The treater has prescribed this medication for long-term use which is not supported by MTUS. The request is not medically necessary.

Tramadol ER 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opioids Page(s): 88, 89,76-78.

Decision rationale: This patient presents with constant right knee and low back pain. The treater is requesting a refill of tramadol ER 150 mg #90. The MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. In this case, recommendation for further use cannot be supported as the treater does not provide before and after pain scale to show analgesia and no specific ADLs are discussed. The treater also does not discuss significant functional improvement with the use of tramadol. There is no urine toxicology or CURES report and aberrant behaviors and possible adverse side effects are not addressed. Given the lack of sufficient documentation for opiate management, the request is not medically necessary.