

Case Number:	CM14-0129817		
Date Assigned:	09/26/2014	Date of Injury:	09/08/2010
Decision Date:	11/07/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/14/2014

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 Internal 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 47-year-old female who reported an injury on 09/08/2010 due to an unknown mechanism. Diagnoses were not reported. Physical examination on 06/23/2014 revealed constant pain in the bilateral knees. The injured worker reported some swelling and buckling. The pain was reported to be a 7 on a scale of 1 to 10. There were complaints of constant pain in the low back. Examination revealed tenderness in the joint line on the knee. Patellar grind test was positive. Anterior drawer test and posterior pivot shift test were negative. McMurray's was negative. Examination of the lumbar spine revealed palpable paravertebral muscle tenderness with spasm. Seated nerve root test was positive. There was guarded and restricted range of motion. Sensation and strength were normal. Treatment plan was for Synvisc injection to the left knee. The rationale and Request for Authorization form were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac Sodium ER (Voltaren SR) 100mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

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

Decision rationale: The decision for Diclofenac Sodium ER (Voltaren SR) 100mg #120 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDs are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The efficacy of this medication was not reported. There was no objective functional improvement or objective decrease in pain reported. The request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Omeprazole 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI symptoms and ca.

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

Decision rationale: The decision for Omeprazole 20mg #120 is not medically necessary. Clinicians should determine if the patient is at risk for gastrointestinal events which include age > 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. The injured worker did not have reports of GI upset or a diagnosis to support the use of this medication. The efficacy was not reported. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Ondansetron 8mg #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 (ODG), Pain Procedure Summary

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

Decision rationale: The decision for Ondansetron 8mg #30 is not medically necessary. The Official Disability Guidelines do not recommend Zofran for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting are common with the use of opioids. The side effects tend to diminish over days to weeks of continued exposure. Studies of opioids' adverse effects including nausea and vomiting are limited to short term duration and have limited application to

long term use. If nausea and vomiting remain prolonged, other etiologies of these symptoms should be evaluated for. The guidelines do not recommend Zofran for nausea and vomiting secondary to opioid use. The medication would not be indicated. The provider's request did not indicate a frequency for the medication. As such, the request is not medically necessary.

Cyclobenzaprine Hydrochloride 7.5 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41,64.

Decision rationale: The decision for Cyclobenzaprine Hydrochloride 7.5 mg #120 is not medically necessary. The California Medical Treatment Utilization Schedule states that cyclobenzaprine (Flexeril) is recommended for a short course of therapy. Flexeril is more effective than placebo in the management of back pain, however, the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. This medication is not recommended to be used for longer than 2 to 3 weeks. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, this request is not medically necessary.

Tramadol ER 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 Tramadol, Ongoing Management Page(s): 82, 93, 94, 113, 78.

Decision rationale: The decision for Tramadol ER 150mg #90 is not medically necessary. The California Medical Treatment Utilization Schedule states central analgesic drugs such as tramadol (Ultram) are reported to be effective in managing neuropathic pain and it is not recommended as a first line oral analgesic. The medical guidelines recommend that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The 4 A's for ongoing monitoring were not reported. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Menthoderm gel 120gm #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 105, 111.

Decision rationale: The decision for Mentherm gel 120gm #1 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. They further indicate that topical salicylates are appropriate for the treatment of pain. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.