

Case Number:	CM14-0172556		
Date Assigned:	10/23/2014	Date of Injury:	05/16/2011
Decision Date:	12/02/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/19/2014

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 North Carolina. 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 54-year-old male with a reported injury on 05/16/2011. The injury reportedly occurred when the he was unloading carpet from a van. His diagnoses included lumbar strain, rule out disc herniation; left knee meniscal tear status post arthroscopy; post-traumatic arthrosis of the left knee; and right knee strain, rule out meniscal tear. The injured worker's past treatments included medications, physical therapy, Supartz injections, and lumbar epidural injections. The injured worker's diagnostic testing included an undated EMG which revealed left sided radiculopathy at L5 and a lumbar spine MRI on 07/01/2013. The injured worker also had a lumbar spine MRI on 04/04/2014 which revealed mild disc degeneration at L2-3 through L5-S1 with mild central canal and foraminal narrowing. Annular fissures were identified at L2-3 and L5-S1 levels. The injured worker's surgical history included a left knee surgery in 2012. The injured worker was evaluated on 09/03/2014 for constant low back pain that was aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, prolonged standing, walking, and walking multiple blocks. The pain was characterized as sharp with radiation into the lower extremities. He rated his pain 8/10. The injured worker complained of difficulty sleeping due to pain. The clinician observed and reported palpable paravertebral muscle tenderness with spasm. The seated nerve root test was positive, range of motion while standing, flexion, and extension were guarded and restricted. Coordination and balance were intact. There was tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot, along the L5 and S1 dermatomal patterns. There was 4/5 strength in the extensor hallucis longus and ankle plantar flexors, L5 and S1 innervated muscles. Ankle reflexes were asymmetric. X-rays were taken but no results were provided with the clinical documentation. Refills were given for all medications. The patient was evaluated on 09/08/2014 for complaints of lower back pain rated 8/10 and described as constant with radiation into the left leg. The left

knee pain was measured at 8/10 and constant. The pain was made better with rest and medication. The patient took Tramadol to help his pain from an 8/10 to a 5/10 and Theraflex cream helps his pain from an 8/10 to a 6/10. The Elavil was not helping him sleep, therefore it was discontinued and Ambien was started. The Flexeril helped his pain from an 8/10 to a 5/10 as it helped his muscle spasms. The pain was made worse with activities. The clinician observed and reported limited range of motion to the lumbar spine with tenderness noted over the paraspinal muscles bilaterally. Kemp's test was positive bilaterally. The straight leg raise was positive at 70 degrees on the right and 60 degrees on the left with pain radiating down to the posterior thighs. Muscle strength was 4/5 in the L4-5 and S1 nerve roots bilaterally. Sensation was decreased in the L4-5 and S1 nerve roots nerve distributions bilaterally. Deep tendon reflexes were 1+ and patellar and Achilles bilaterally. Examination of the left knee revealed decreased range of motion greater than the right. Valgus stress, varus stress, and patellofemoral grind test were positive. Muscle strength was 4/5 in the left quadriceps. The clinician reported that the patient had failed conservative treatment measures including Supartz injections with little relief. The patient did not want to proceed with anything invasive at that time for the left knee. The clinician requested authorization for a 1 time protein rich plasma injection to the left knee. The clinician also requested Keratek analgesic gel for chronic pain. The patient was awaiting independent medical review for lumbar spine surgery. Medications were dispensed in house and there were no signs of abuse, overuse, or adverse reactions. The injured worker's medications were noted to include Flexeril 10 mg every 8 hours with food, Ultram 50 mg 1 to 2 tablets by mouth every 4 to 6 hours for pain, Ambien 5 mg 1 tablet by mouth at bedtime, and Keratek gel applied in a thin layer to affected area 2 to 3 times per day as directed by the physician. The request for authorization was submitted on 10/16/2014. No rationale for the request was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription for quazepam 15mg CIV #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The request for quazepam 15 mg CIV #30 is not medically necessary. The patient continued to complain of back and knee pain. The California MTUS Chronic Pain Guidelines do not recommend long term use of benzodiazepines because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. The patient did report spasms, but reported relief with Flexeril. The patient's muscle spasms improved with the use of a nonbenzodiazepine. Additionally the requested did not include a frequency of dosing. Therefore the request for quazepam 15 mg CIV #30 is not medically necessary.

1 Prescription for fenoprofen calcium 400mg #120: Upheld

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

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

Decision rationale: The request for fenoprofen calcium 400 mg #120 is not medically necessary. The patient continued to complain of back and knee pain. The California MTUS Chronic Pain Guidelines recommend nonsteroidal anti-inflammatories for osteoarthritis of the knee at the lowest dose for the shortest period of time in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. The provided documentation did not indicate that the patient had tried acetaminophen. Additionally the request did not include a frequency and dosing. Therefore the request for fenoprofen calcium 400 mg #120 is not medically necessary.

1 Prescription for Omeprazole 20mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request for Omeprazole 20 mg #120 is not medically necessary. The patient continued to complain of low back and knee pain. The California MTUS Chronic Pain Guidelines recommend proton pump inhibitors only in patients who are at risk for gastrointestinal events and concurrently taking nonsteroidal anti-inflammatory drugs. Based on the provided documentation the patient would have had minimal risk for gastrointestinal events and a nonsteroidal anti-inflammatory drug would have been recommended without the use of a proton pump inhibitor. Additionally, the request for a nonsteroidal anti-inflammatory drug has been denied so the ancillary request for a proton pump inhibitor would not be indicated. The request did not include a frequency of dosing. Therefore the request for 1 prescription for Omeprazole 20 mg #120 is not medically necessary.

1 Prescription for ondansetron ODT 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-TWC

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 (for opioid nausea)

Decision rationale: The request for ondansetron ODT 8mg #30 is not medically necessary. The provided documentation did not indicate complaints of nausea or vomiting. The Official Disability Guidelines state that ondansetron is a serotonin 5-HT₃ receptor antagonist. It is FDA

approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for postoperative use. Acute use is FDA approved for gastroenteritis. As with other anti-emetics, routine prophylaxis is not recommended for injured workers in whom there is little expectation that the nausea and/or vomiting will occur postoperatively. There was no documentation submitted that this worker was being treated with cancer chemotherapy, full body or single dose irradiation or that he was a candidate for surgery with high expectation of postoperative nausea and vomiting. Additionally the request did not include a frequency of dosing. Therefore the request for 1 prescription for ondansetron ODT 8 mg #30 is not medically necessary.

1 Prescription for cyclobenzaprine hydrochloride 7.5mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: The request for 1 prescription for cyclobenzaprine hydrochloride 7.5 mg is not medically necessary. The patient continued to complain of back and knee pain. The California MTUS Chronic Pain Guidelines recommend cyclobenzaprine as an option for muscle spasms using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. The provided documentation indicates that the patient has been taking cyclobenzaprine since at least 03/24/2014 which indicates a length of use in excess of those recommended by the guidelines. Additionally, the request did not indicate a frequency of dosing or an amount to be dispensed. Therefore the request for cyclobenzaprine hydrochloride 7.5 mg is not medically necessary.

1 Prescription for tramadol ER 150mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

Decision rationale: The request for tramadol ER 150 mg is not medically necessary. The patient continued to complain of back and knee pain. The California MTUS Chronic Pain Guidelines recommend discontinuation of opioids if there is no overall improvement in function, unless there are extenuating circumstances. On 03/24/2014 the patient reported the tramadol and Flexeril reduced his pain from a 9/10 to a 6-7/10. Successive notes up through 09/08/2014 indicate that the patient's pain was rated an 8-9/10 and improved to 5-6/10 with the tramadol indicating no change in the patient's pain status. Additionally, the patient has not returned to work. No extenuating circumstances were presented. The request does not include a frequency of dosing or an amount to be dispensed. Therefore the request for 1 prescription for tramadol ER 150 mg is not medically necessary.

