

Case Number:	CM14-0075643		
Date Assigned:	07/18/2014	Date of Injury:	07/23/2012
Decision Date:	10/17/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/23/2014

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 Pain Management 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 50-year old male with a date of injury of July 23, 2012. He was driving his patrol car when a girl driving another vehicle thought she had green light and hit his car on the driver's side. He was diagnosed with (a) lumbar discopathy with radiculitis, (b) left hip degenerative joint disease and (c) left knee degenerative tear of the meniscus and degenerative joint disease. In an orthopedic evaluation report dated January 24, 2014 it was indicated that he complained of persistent pain in the low back and left knee which was aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting and standing as well as walking multiple blocks. On examination of the lumbar spine tenderness was noted over the mid-to-distal lumbar segments. Pain was also noted with terminal motion. Seated nerve root test was positive. Dysesthesia was also noted along the L4-L5 dermatome. Examination of the left hip was unchanged, pain and discomfort was noted over the posterolateral region. Examination of the left knee tenderness was noted over the anterior joint line space. McMurray's test and Patellar Compression tests were positive. Terminal flexion was painful. Authorization for left knee arthroscopy with repair of internal derangement was requested. In a most recent progress note dated March 4, 2014 it was indicated that he complained of left knee pain and lower back pain. Objective findings to the left knee included positive patellar grind test and McMurray's test. He was advised to continue with his home exercise program and with his current medication regimen. This is a review of the requested Levofloxacin 750mg, #30, Tramadol 150mg, #90, Omeprazole 20mg, #120 and Ondansetron 8mg, #30 x2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Levofloxacin 750mg #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 Infectious Diseases procedure Summary, Mosby's Drug Consult

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

Decision rationale: The medical records received have limited information to support the necessity of Levofloxacin 750 mg, #30. As per the Official Disability Guidelines, this medication is recommended as a first-line treatment for osteomyelitis, chronic bronchitis, and pneumonia. If this is being requested as post operative medication as the injured worker is expected to undergo surgery, there should be documentation that the requested surgery has occurred. In this case, there is lack of documentation that the requested surgery has happened and there is nothing in the medical records that indicate that the injured worker is diagnosed with the conditions for which this medication is used for. Therefore, the requested Levofloxacin 750 mg, #30 is not considered medically necessary.

Tramadol 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 Opioids, long-term assessment Page(s): 88-89.

Decision rationale: Based on medical records review, there is no documentation of the length of time that the injured worker has been utilizing this medication as well as the responses to previous use as a decrease in pain level, increased range of motion, and increased ability to perform activities of daily living. As per the California Medical Treatment Schedule, the criteria for long-term use of opioids included documentation of pain and functional improvement; a comparison to baseline maybe possible. Furthermore, the same guidelines accentuate the necessity for screening instrument for abuse/addiction, which was also not found on the medical records submitted for review. Therefore, the request for Tramadol 150mg #90 is not considered medically necessary.

Omeprazole20mg #120: Upheld

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

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

Decision rationale: From the medical records reviewed, there was no documentation of any gastrointestinal complaints nor there were diagnoses for which omeprazole was indicated such as heartburn, gastroesophageal reflux disease, peptic ulcer, dyspepsia and Zollinger-Ellison syndrome. Therefore, the requested Omeprazole 20mg #120 is not considered medically necessary.

Ondansetron 8mg #30 x 2 Quantity 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 , Proton Pump Inhibitors

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

Decision rationale: The medical records received have limited information to support the necessity of Ondansetron 8 mg, #30 x 2. The Medical Treatment Utilization Schedule guideline is silent with regard to this medication; as such other evidence-based guidelines were consulted and it is noted that Ondansetron (Zofran) is a drug serotonin 5-HT₃ receptor antagonist and is approved by the Food and Drug Administration for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also approved for postoperative use and acute usage is approved for gastroenteritis. As per the Official Disability Guidelines, it was stipulated that this medication is not recommended for nausea and vomiting secondary to chronic opioid use. Although there is an indication that this injured worker is utilizing opioid medications, there were no complaints of nausea and vomiting. If this is being requested as post operative medication as the injured worker is expected to undergo surgery, there should be documentation that the requested surgery has occurred. In this case, there is lack of documentation that the requested surgery has been used and there are no complaints of nausea and vomiting. The requested Ondansetron is therefore considered not medically necessary.