

Case Number:	CM14-0014899		
Date Assigned:	02/28/2014	Date of Injury:	07/16/2012
Decision Date:	03/11/2015	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/05/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 46 year old male with an injury date on 07/16/2012. Based on the 08/28/2013 most recent progress report provided by the treating physician, the patient complains of shoulder and back pain. The patient states that he continues to have worsening of his back pain symptoms with band-like symptoms across his lower back, predominantly on the left side and multifocal pain in the right upper extremity, pointing at his the shoulder, elbow, wrist, and fingers with numbness in the third, fourth and fifth fingers when he places pressure on his elbow. Right shoulder range of motion is restricted approximately 60%. Pain is noted with both loading and distracting examination techniques. Straight leg raise is positive. The patient's diagnoses and work status were not mentioned in the provided reports. Per treating physician, MRI of the lumbar spine from March shows multilevel degenerative changes of the lumbar spine with no acute disc herniation. Treatment to date includes extensive therapy for both of this issue, anti-inflammatory and pain medications. There were no other significant findings noted on this report. The utilization review denied the request for (1) Orphenadrine#60, (2) Ondansetron #4, and (3) Amoxicillin #20 on 01/24/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 07/12/2013 to 08/28/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO ORPHENADRINE (NORFLEX) 100MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65.

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

Decision rationale: According to the 08/28/2013 report, this patient presents with a rotator cuff injury and back pain. The current request is for Orphenadrine (Norflex) 100mg #60. For muscle relaxants for pain, the MTUS Guidelines page 63 state recommended non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they showed no benefit beyond NSAIDs and pain and overall improvement. A short course of muscle relaxant may be warranted for patient's reduction of pain and muscle spasms. Review of the available records indicate that this medication is been prescribed longer then the recommended 2-3 weeks. The treating physician is requesting Orphenadrine #60 and it is unknown exactly when the patient initially started taking this medication. Orphenadrine is not recommended for long term use. The treater does not mention that this is for a short-term use to address a flare-up or an exacerbation. Therefore, the current request IS NOT medically necessary.

RETRO ONDANSETRON (ZOFTRAN ODT) 8MG #4: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG PAIN

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation pain chapter: antiemetics

Decision rationale: According to the 08/28/2013 report, this patient presents with a rotator cuff injury and back pain. The current request is for Retro Ondansetron (Zofran ODT) 8mg #4 but the treating physician's report containing the request is not included in the file. The most recent progress report is dated 08/28/13 and the utilization review letter in question is from 01/24/2014. The MTUS and ACOEM Guidelines do not discuss ondansetron. However, ODG Guidelines has the following regarding antiemetics, "Not recommended for nausea and vomiting secondary to chronic opioid use. These side effects tend to diminish over days to weeks of continued exposure. Studies of opioid adverse effects including nausea and vomiting are limited to short-term duration (less than four weeks)." Review of the provided reports does not indicate the patient had surgery recently or is schedule to have surgery soon. Ondansetron is only recommended for post-op nausea per ODG. The current request IS NOT medically necessary.

RETRO AMOXICILLIN (AUGMENTIN) 500MG #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG INFECTIOUS DISEASES

AMOXICILLIN-CLAVULANTE (AUGMENTIN) AND ON THE NATIONAL GUIDELINE CLEARINGHOUSE (NGC)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Infectious Diseases chapter: Amoxicillin (Augmentin)

Decision rationale: According to the 08/28/2013 report, this patient presents with a rotator cuff injury and back pain. The current request is for Retro Amoxicillin (Augmentin) 500 Mg #20 but the treating physician's report containing the request is not included in the file. The most recent progress report is dated 08/28/13 and the utilization review letter in question is from 01/24/2014. Amoxicillin is a penicillin antibiotic that fights bacteria. Regarding Amoxicillin, ODG guidelines recommended as first-line treatment for bite wounds and other conditions. See Skin & soft tissue infections: bite wound. In reviewing the provided reports, the treating physician does not mention that the patient has bite wounds or skin wound infection and why patient needs Amoxicillin. ODG support the use of Amoxicillin as first-line treatment to soft tissue infections, which is not present in this patient. The current request IS NOT medically necessary.