

Case Number:	CM14-0177890		
Date Assigned:	10/31/2014	Date of Injury:	11/01/2001
Decision Date:	01/29/2015	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	10/27/2014

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 48 year old female with an injury date on 11/01/2001. Based on the 10/31/2013 progress report provided by the treating physician, the diagnoses are:1. Full-thickness ACL tear of the right knee2. History of industrial injury of the right knee3. Previous history of right knee arthroscopy with [REDACTED] in 2001 and ACL reconstructive surgery of the right knee with Achilles tendon allograft on February 22, 2013According to this report, the patient complains of right knee pain. The patient had undergone arthroscopic ACL reconstruction of the right knee 8 months ago. Physical exam shows "stable Lachman, stable anterior drawer and negative pivot shift. "There were no mentions of patient's medications in the reports. There were no other significant findings noted on this report. The utilization review denied the request on 10/03/2014. The requesting provider provided one progress report dated 10/31/2013 and one AME report dated 01/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine hydrochloride 7.5 mg # 120 DOS 7/12/12: Upheld

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

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

Decision rationale: According to the 10/31/2013 report, this patient presents with right knee pain. The current request is for Cyclobenzaprine hydrochloride 7.5 mg # 120 DOS 7/12/12. 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 reports show no mentions of this medication and it is unknown exactly when the patient initially started taking this medication. However, the treater is requesting Cyclobenzaprine hydrochloride # 120. Cyclobenzaprine 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 request is not medically necessary.

Ondansetron ODT 8 mg # 30 with 2 refills DOS 7/12/12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosbys 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), Antiemetics

Decision rationale: According to the 10/31/2013 report, this patient presents with right knee pain. The current request is for Ondansetron ODT 8 mg # 30 with 2 refills DOS 7/12/12. 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 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 request is not medically necessary.

Omeprazole delayed release capsules 20 mg # 120 DOS 7/12/12: Upheld

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

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

Decision rationale: According to the 10/31/2013 report, this patient presents with right knee pain. The current request is for Omeprazole delayed release capsules 20 mg # 120 DOS 7/12/12. The MTUS Guidelines state Omeprazole is recommended for patients at risk for gastrointestinal

events if used prophylactically for concurrent NSAIDs. MTUS requires proper GI assessment such as the age, concurrent use of anticoagulants, ASA, history of PUD, gastritis, etc. Review of reports show no mentions of this medication and it is unknown exactly when the patient initially started taking this medication. The reports do not show that the patient has gastrointestinal side effects with medication use. Patient is currently not on NSAID. There is no discussion regarding GI assessment as required by MTUS. MTUS does not recommend routine use of GI prophylaxis without documentation of GI risk. In addition, the treater does not mention symptoms of gastritis, reflux or other condition that would require a PPI. The request is not medically necessary.

Medrox pain relief ointment 120 gm x 2 refills DOS 7/12/12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the 10/31/2013 report, this patient presents with right knee pain. The current request is for Medrox pain relief ointment 120 gm x 2 refills DOS 7/12/12. Medrox contains methyl salicylate, a topical NSAID. The MTUS Guidelines state that topical NSAIDs are indicated for peripheral joint arthritis and tendinitis. In this case, the treating physician has not clearly documented that the right knee complaint is arthritic in nature and MTUS does not support topical NSAIDs for spinal conditions. The request is not medically necessary.

Cidafex tablets # 120 DOS 7/12/12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: According to the 10/31/2013 report, this patient presents with right knee pain. The current request is for Cidaflex tablets # 120 DOS 7/12/12. Cidaflex contains Glucosamine sulfate and Chondroitin. Regarding Glucosamine, the MTUS guidelines state "Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis." In this case, the treating physician has not clearly documented that the right knee complaint is arthritic in nature. The request is not medically necessary.