

Case Number:	CM14-0038533		
Date Assigned:	08/08/2014	Date of Injury:	09/12/2009
Decision Date:	01/21/2015	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	04/01/2014

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 Occupational 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:

Patient is a 41 year-old male with date of injury 09/12/2009. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 10/06/2014, lists subjective complaints as increasing right knee and leg pain. Objective findings: Examination of the right leg revealed tenderness in the right hip, knee joint line, and distal femur. Patellar grind test and Fabere were positive. Anterior drawer test and posterior pivot shift test were negative. There was crepitus and painful range of motion in the knee. No evidence of instability. Normal quadriceps and hamstring strength. Diagnosis: 1. Hip and thigh sprain. Original reviewer modified medication request to Naproxen Sodium 550mg with no refills, Cyclobenzaprine 7.5mg, #20, and Omeprazole 20mg with no refills. The medical records supplied for review document that the patient has been taking the following medications for at least as far back a six months. Medication: 1. Naproxen Sodium 550mg, #1002. Cyclobenzaprine HCL 7.5mg, #20 SIG: PO Q8H3. Cidaflex, #1204. Ondansetron 8mg, #30 SIG: 1 PRN5. Omeprazole 20mg, #120 SIG: PO 12H PRN6. Medrox Pain Relief Ointment 120gms, x27. Tramadol HCL 150mg, #90 SIG: once a day.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen Sodium 550mg #100 DOS 10/11/12, 01/21/13 and 5/13/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. Naproxen Sodium 550mg #100 DOS 10/11/12, 01/21/13 and 5/13/13 is not medically necessary.

Cyclobenzaprine HCL 7.5mg #20 DOS 10/11/12, 01/21/13 and 5/13/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Procedure Summary- Muscle relaxants

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

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants such as cyclobenzaprine. The patient has been taking cyclobenzaprine for at least 6 months, long past the 2-3 weeks recommended by the MTUS. Therefore, the request is not medically necessary.

Cidaflex #120 DOS 10/11/12: Upheld

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

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

Decision rationale: According to the MTUS, glucosamine is recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Cidaflex is a compounded mixture of glucosamine, chondroitin, and MSM. Neither of the MTUS nor the ODG support chondroitin. Cidaflex #120 DOS 10/11/12 is not medically necessary.

Ondansetron 8mg #30 x 2 DOS 10/11/12, 01/21/13 and 5/13/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Procedures Summary Anti-emetics Mosby's Drug Consult Zofran

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

Decision rationale: There is no documentation that the patient is suffering nausea or vomiting due to any of the approved indications for ondansetron. Current approved indications include nausea as a result of cancer chemotherapy, radiation of the abdomen or total body radiotherapy, or postoperative nausea/vomiting. Ondansetron not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron 8mg #30 x 2 DOS 10/11/12, 01/21/13 and 5/13/13 is not medically necessary.

Omeprazole 20mg #120 DOS 10/11/12, 01/21/13 and 5/13/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Omeprazole 20mg #120 DOS 10/11/12, 01/21/13 and 5/13/13 is not medically necessary.

Medrox pain relief ointment 120gm X 2 DOS 10/11/12, 01/21/13 and 05/13/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 28, 112-113.

Decision rationale: Medrox ointment contains a topical analgesic with the active ingredients, capsaicin 0.0375%, and menthol USP 5% used for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness. Capsaicin 0.025% topical is recommended only as an option in patients who have not responded or are intolerant to other treatments. According to MTUS there have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over 0.025% formulation would provide any further efficacy. Medrox pain relief ointment 120gm X 2 DOS 10/11/12, 01/21/13 and 05/13/13 is not medically necessary.

Tramadol HCL ER 150mg #90 DOS 5/13/13: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is no documentation of functional improvement supporting the continued long-term use of tramadol. Tramadol HCL ER 150mg #90 DOS 5/13/13 is not medically necessary.