

<b>Case Number:</b>	CM14-0083081		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	05/08/2011
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	05/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2014

### 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 Family Medicine and is licensed to practice in New Jersey. 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 worker is a 29 year old female who was injured on 5/8/11 involving her left knee. She was diagnosed with left knee pain, sprain/strain, left knee meniscus tear, and left knee internal derangement. She had a prior right knee injury leading to dislocation of the patella. She was treated with oral and topical analgesic medications, steroid injection, physical therapy, modified duty, and a knee brace. From 2012 to 2013, the worker was pregnant, and although there were frequent requests for the worker to get left knee surgery, consideration of this surgery was postponed until after her delivery. Surgery (left knee meniscectomy and debridement) was planned for 5/15/14, and a request on 5/1/14 was made for post-op physical therapy, Keflex, Colace, Zofran, Ibuprofen, vitamin C, and Tylenol #3 in preparation for the surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Keflex 500mg #4:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/9636336>; Am Fam Physician 1998 June 57(11):2731-40.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical

Evidence: Bert JM, Antibiotic prophylaxis for arthroscopy of the knee: is it necessary?, Arthroscopy, 2007 Jan;23(1):4-6 (<http://www.ncbi.nlm.nih.gov/pubmed/17210420>).

**Decision rationale:** The MTUS Guidelines do not specifically address antibiotic prophylaxis for knee arthroscopy. Although research is limited in this area, a retrospective review, which involved over 3000 participants, revealed that there was no significant reduction in the infection rate with antibiotic prophylaxis compared to without. In the case of this worker, she was preparing for a left knee meniscectomy and Keflex was prescribed for prophylaxis use. Such as, Keflex 500mg #4 is not medically necessary.

**Zofran 4mg:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain section, Anti-emetic use for opioid-related nausea, Zofran.

**Decision rationale:** The MTUS is silent on the use of Zofran. The ODG states that ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use and is only approved for use in chemo-therapy induced pain or malignancy-induced pain. Antiemetics in general, as also stated in the ODG, are not recommended for nausea related to chronic opioid use, but may be used for acute short-term use (less than 4 weeks) as they have limited application for long term use. Nausea tends to diminish over time with chronic opioid use, but if nausea remains prolonged, other etiologies for the nausea must be evaluated for. Also there is no high quality literature to support any one treatment for opioid-induced nausea in chronic non-malignant pain patients. In the case of this worker, Zofran was prescribed before the surgery took place, and there was no mention of nausea reported by the worker in the notes available for review. It is more reasonable to have documentation of nausea postoperatively before making a request for a medication to treat nausea. Therefore, the Zofran is not medically necessary.

**Colace 100mg #10:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.guideline.gov/content.aspx?id=15434&search=docusate+sodium-Guideline> Title Management of Constipation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain section, Opioid-induced constipation treatment.

**Decision rationale:** The MTUS Chronic Pain Guidelines discuss very little about medication use for constipation besides the recommendation to consider treating constipation when initiating opioids. The ODG states that first line therapy for constipation related to opioid use should begin

with physical activity, staying hydrated by drinking enough water, and eating a proper diet rich in fiber. Other food-based supplements such as eating prunes (or drinking prune juice) or fiber supplements may be attempted secondarily. If these strategies have been exhausted and the patient still has constipation, then using laxatives as needed may be considered. In the case of this worker, there was no evidence of constipation, and the prescription was intended for potential post-operative constipation. It is more reasonable to wait until there is a complaint of constipation from the worker before prescribing any medication for such. Therefore, the Colace is not medically necessary.

**Vitamin C 500mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/6811487>; Int J Vitam Nutr Res Suppl. 1982;23:277-86.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Irvin TT, Vitamin C requirements in postoperative patients, Int J Nutr Res Suppl., 1982;23:277-86 (<http://www.ncbi.nlm.nih.gov/pubmed/?term=6811487>).

**Decision rationale:** The MTUS Guidelines do not address use of vitamin C postoperatively. There is no substantial and clinically significant evidence to suggest that taking a vitamin C supplement postoperatively will improve outcomes. Even if there were evidence for vitamin C supplementation postoperatively, eating vitamin C-rich foods would certainly be simpler and easily match or exceed the dose requested (citrus, peppers, broccoli, brussel sprouts, kale, strawberries, etc.) and do not require a prescription or a request for approval. Therefore, the vitamin C supplement is not medically necessary.