

Case Number:	CM14-0207784		
Date Assigned:	12/22/2014	Date of Injury:	07/22/2014
Decision Date:	03/16/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/11/2014

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, Arizona
 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 injured worker is a 59-year-old male who reported an injury on 07/22/2014 due to cumulative trauma. On 11/28/2014, the injured worker presented for an orthopedic evaluation. The injured worker had complaints of constant severe pain in the bilateral hips, left greater than right, but was aggravated by lifting, ascending and descending stairs, twisting, bending, and prolonged sitting. He also had frequent pain in the bilateral knees aggravated by squatting, kneeling, ascending and descending stairs, walking multiple blocks, and prolonged standing. Examination of the bilateral hips noted tenderness to palpation in the posterolateral aspect, left greater than right. There was a positive Faber sign and reproducible pain in the lumbar spine that extended over the top of the hips in the posterolateral region at the possible L5 root. Examination of the bilateral knees revealed tenderness in the anterior joint line space with a positive patellar grind test. There was crepitus with painful range of motion. There was no clinical evidence of instability. X-rays of the bilateral knees revealed degenerative changes. The diagnoses were internal derangement of the bilateral hips, internal derangement of the bilateral knees, and lumbar discopathy rule out radiculopathy. The treatment plan included cyclobenzaprine hydrochloride 7.5 mg, ondansetron 8 mg, omeprazole 20 mg, tramadol ER 150 mg, an MRI of the bilateral knees, and EMG and NCS of the bilateral lower extremities, and pain control management referral. A current medication list was not provided. There was no rationale submitted for review. The Request for Authorization form was dated 11/11/2014.

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: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41.

Decision rationale: The request for cyclobenzaprine hydrochloride 7.5 mg with a quantity of 120 is not medically necessary. The California MTUS Guidelines recommend cyclobenzaprine as an option for a short course of therapy. The greatest effect of this medication is in the first 4 days of treatment, suggesting that shortest courses may be better. It appears the injured worker has been prescribed this medication previously. However, the treatment history and length of time the injured worker has been prescribed cyclobenzaprine were not provided. The request for cyclobenzaprine hydrochloride 7.5 mg with a quantity of 120 exceeds the guideline recommendations of a short term treatment. The efficacy of the prior use of the medication was not provided. Additionally, the provider's request did not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Ondansetron 8mg ODT #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request for ondansetron 8 mg ODT with a quantity of 30 is not medically necessary. The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is common with opioid use. The side effects tend to diminish over days to weeks of continued exposure. Opioid adverse effects include nausea and vomiting and are limited to short term duration. If nausea and vomiting remain prolonged other etiologies of these symptoms should be evaluated for. As the guidelines do not recommend ondansetron for nausea and vomiting secondary to opioid use, the medication would not be indicated. There was no information on treatment history and length of time the injured worker has been prescribed ondansetron and the efficacy of the prior use of the medication was not provided. Additionally, the provider's request did not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Omeprazole 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-71.

Decision rationale: The request for omeprazole 20 mg with a quantity of 120 is not medically necessary. According to the California MTUS Guidelines, proton pump inhibitors may be recommended for injured workers with dyspepsia secondary to NSAID therapy or for those taking NSAID medications who are at moderate to high risk for gastrointestinal events. The injured worker does not have a diagnosis congruent with the guideline recommendations such as dyspepsia. Additionally, the injured worker is not at moderate to high risk for gastrointestinal events. The efficacy of the prior use of the medication was not provided to support continued use. Additionally, the provider did not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Tramadol ER 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The request for tramadol ER 150 mg with a quantity of 90 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing monitoring of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There was no information of treatment history and length of time the injured worker has been prescribed tramadol. Additionally, the efficacy of the prior use of the medication was not provided for review. There was no information on a current urine drug screen or a current signed pain contract listed. As such, medical necessity has not been established.

MRI (B) knees: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 304.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

Decision rationale: The request for an MRI of the bilateral knees is not medically necessary. The California MTUS/ACOEM Guidelines state that most knee problems improve quickly once any red flag issues are ruled out. Special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation fails. There was no evidence of previous courses of conservative treatment the injured worker underwent. The efficacy of those treatments was also not provided for review. There were no neurological deficits noted on physical examination. As such, medical necessity has not been established.

EMG/NCS of (B) lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Nerve Conduction Velocity (NCV).

Decision rationale: The request for an EMG/NCS of the bilateral lower extremities is not medically necessary. The California MTUS/ACOEM Guidelines state that an EMG may be useful to identify subtle, focal neurological dysfunction in injured workers with low back symptoms lasting more than 3 to 4 weeks. The Official Disability Guidelines further state that an NCV is not recommended for the lower extremities. There is minimal justification for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. There was no rationale given for the request. Additionally, the medical documentation lacked evidence of the injured worker's failure to respond to conservative treatment to include physical therapy and medications. The referenced guidelines do not support a nerve conduction study for the lower extremities. As such, medical necessity has not been established.

Pain control management referral: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

Decision rationale: The request for a pain control management referral is not medically necessary. The California MTUS Guidelines state that if the complaint persists, the provider needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The documentation provided no evidence that the current treatment requested for the injured worker has failed to result in improvement and that he requires additional pain management for control of pain. There was no rationale provided. Based on the submitted documentation reviewed and the medical guidelines, a pain control management referral would not be indicated. As such, medical necessity has not been established.