

Case Number:	CM13-0071597		
Date Assigned:	01/08/2014	Date of Injury:	03/12/2012
Decision Date:	06/06/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	12/27/2013

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 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:

This female claimant sustained a work injury on 3/12/12 involving the right hip and low back. She had a diagnosis of a right hip labral tear that required osteoplasty and debridement in May 2013. She had been in pain patches and had develop nausea for which she had been on Zofran. Her pain had also been managed with Dilaudid until she completed a detoxification program in April 2013. An exam note on 10/29/13 indicated she continued to have right hip pain. She had completed physical therapy. She alternated with Tylenol and Naproxen for pain relief. She had been on Naproxen since at least November 2012. Physical findings included painful range of motion of the right hip and weakness. She was to continue her rehabilitation program and Naproxen along with ice and heat.

IMR ISSUES, DECISIONS AND RATIONALES

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

ZOFRAN 8MG #10: 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), Antiemetics.

Decision rationale: The MTUS and ACOEM guidelines do not comment on anti-emetics. According to the Official Disability Guidelines (ODG), anti-emetics are not recommended for nausea and vomiting secondary to chronic opioid use. They are recommended for acute use as noted below per Food and Drug Administration (FDA)-approved indications. Nausea and vomiting is common with use of opioids. 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) and have limited application to long-term use. If nausea and vomiting remains prolonged, other etiologies of these symptoms should be evaluated for. The differential diagnosis includes gastroparesis (primarily due to diabetes). The current research for treatment of nausea and vomiting as related to opioid use primarily addresses the use of anti-emetics in patients with cancer pain or those utilizing opioids for acute/postoperative therapy. The recommendations based on these studies cannot be extrapolated to chronic non-malignant pain patients. Ondansetron (Zofran®) is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis. In this case, the claimant has been off of opioids for several months. Zofran is not indicated for nausea due to non-steroidal anti-inflammatory drugs (NSAIDs) use. Thus, the request for Zofran 8mg, #10, is not medically necessary.

NAPROXEN 550MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 89.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 62.

Decision rationale: According to the MTUS guidelines, non-steroidal anti-inflammatory drugs (NSAIDs) for osteoarthritis (including knee and hip) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer gastrointestinal side effects at the risk of increased cardiovascular side effects, although the Food and Drug Administration (FDA) has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. For acute exacerbations of chronic pain: NSAIDs is recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain,

and that acetaminophen had fewer side effects. The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. For chronic low back pain: NSAIDs is recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. For neuropathic pain, there is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. Besides the above well-documented side effects of NSAIDs, there are other less well-known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. Based on the MTUS guidelines, Naproxen is not supported for long-term use and is not found to be superior to Tylenol for pain. The claimant has been on Naproxen for over a year with continued pain. Thus, further use of Naproxen is not medically necessary.