

<b>Case Number:</b>	CM14-0124378		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	09/04/1997
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 53-year-old female who reported an injury on 09/04/1997. The mechanism of injury was not provided. On 06/19/2014, the injured worker presented with pain in the left shoulder aggravated by forward reaching, lifting, pushing, and pulling while working at or above shoulder level. Upon examination of the shoulder, there was tenderness around the anterior glenohumeral region and subacromial space. There was positive Hawkins and impingement sign. The rotator cuff function appears intact but painful. There was reproducible symptomology with internal rotation and forward flexion, and standing flexion and extension are guarded and restricted. The diagnoses were brachial neuritis, cervicalgia, trigger finger, cubital tunnel syndrome, and de Quervain's /radial styloid tenosynovitis. A current medication list was not provided. The provider recommended Ondansetron and Mentherm gel however, provider's rationale was not provided. The Request for Authorization form was dated 07/11/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**30 Ondansetron 8 MG:** Upheld

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

**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 30 Ondansetron 8 mg 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 the use of opioids. The side effects tend to diminish over days to weeks of continued exposure. Studies of opioid effects include nausea/vomiting is limited to short term duration and have limited application to long term use. 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 indicated. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, this request is not medically necessary.

**Menthoderm Gel 120 GM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines Topical Analgesics.

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

**Decision rationale:** The request for Menthoderm gel 120 gm is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines note that Lidoderm is the only formulation of Lidocaine that is recommended. There is lack of evidence of a failed trial of an antidepressant or anticonvulsant. Additionally, the guidelines note that Lidoderm is the only form of Lidocaine approved for topical application. The provider's request does not indicate the site that the gel is intended for or the frequency of the medication in the request as submitted. As such, this request is not medically necessary.