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| Case Number: | CM14-0177467 | | |
| Date Assigned: | 10/30/2014 | Date of Injury: | 01/26/2012 |
| Decision Date: | 12/16/2014 | UR Denial Date: | 10/15/2014 |
| Priority: | Standard | Application Received: | 10/27/2014 |

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 Management 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:

According to the records made available for review, this is a 44-year-old male with a 1/26/12 date of injury. At the time (9/24/14) of the request for authorization for 40 Tablets of Vicosetron (Hydrocodone/APAP/Ondansetron) 10/300/2 mg, 1 bottle of Keratek Gel 4 oz., and 120 capsules of Gabapentin/Pyridoxine 250/10mg, there is documentation of subjective (persistent left shoulder pain, weakness) and objective (weakness to external rotation) findings, current diagnoses (clinical and MRI scan evidence of a large full thickness rotator cuff tear of the left shoulder), and treatment to date (medication including Vicosetron, Keratek Gel, and Gabapentin/Pyridoxine for at least 2 months). Regarding 40 Tablets of Vicosetron (Hydrocodone/APAP/Ondansetron) 10/300/2 mg, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, or acute use for gastroenteritis; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Vicosetron use to date. Regarding Keratek Gel 4 oz., there is no documentation of neuropathic pain and that trials of antidepressants and anticonvulsants have failed; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Keratek use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicosetron (Hydrocodone/APAP/Ondansetron) 10/300/2 mg #40: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Antiemetics (for opioid nausea) and Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: Specifically regarding hydrocodone/APAP, MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. Specifically regarding Ondansetron, ODG identifies documentation of nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, or acute use for gastroenteritis, as criteria necessary to support the medical necessity of Ondansetron (Zofran). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of clinical and MRI scan evidence of a large full thickness rotator cuff tear of the left shoulder. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, there is no documentation of nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, or acute use for gastroenteritis. Furthermore, given documentation of treatment with Vicosetron for at least 2 months, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Vicosetron use to date. Therefore, based on guidelines and a review of the evidence, the request for 40 Tablets of Vicosetron (Hydrocodone/APAP/Ondansetron) 10/300/2 mg is not medically necessary.

1 bottle of Keratek Gel 4 oz: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: Kera-Tek contains menthol and methyl salicylate gel. MTUS Chronic Pain Medical Treatment Guidelines identifies that topical analgesics are recommended for

neuropathic pain when trials of antidepressants and anticonvulsants have failed, as criteria necessary to support the medical necessity of topical analgesics. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of clinical and MRI scan evidence of a large full thickness rotator cuff tear of the left shoulder. However, there is no documentation of neuropathic pain and that trials of antidepressants and anticonvulsants have failed. In addition, given documentation of treatment with Keratek for at least 2 months, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Keratek use to date. Therefore, based on guidelines and a review of the evidence, the request for Keratek Gel 4 oz. is not medically necessary.

Gabapentin/Pyridoxine 250/10mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Vitamin B

Decision rationale: Regarding Neurontin, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (gabapentin). Regarding Pyridoxine (Vitamin B), MTUS does not address this issue. ODG identifies that vitamin B is not recommended; that it is frequently used for treating peripheral neuropathy but its efficacy is not clear. Within the medical information available for review, there is documentation of diagnoses of clinical and MRI scan evidence of a large full thickness rotator cuff tear of the left shoulder. However, the requested Gabapentin/Pyridoxine 250/10mg contains at least one drug (Pyridoxine) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for 120 capsules of Gabapentin/Pyridoxine 250/10mg is not medically necessary.