

Case Number:	CM14-0022830		
Date Assigned:	06/27/2014	Date of Injury:	10/23/1998
Decision Date:	07/29/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	02/24/2014

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, 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 40-year-old female who reported an injury on 10/23/1998. The mechanism of injury was not provided. On 01/24/2014, the injured worker presented with low back, left leg, right shoulder and arm and neck pain. Current medications include oxycodone, Lyrica, Lexapro, omeprazole, ondansetron, MiraLAX, Promolaxin, Lidoderm patch, diphenhydramine HCl, diazepam, bupropion and trazodone. Upon examination of the lumbar spine, there was decreased sensation to the left C5, C6 and C7 and decreased sensation to the right C5 and C6. There was a positive Tinel's on the left cubital and carpal tunnels and a positive left Phalen's. Examination of the right shoulder revealed tenderness noted over the AC joint and positive impingement signs. Painful range of motion was noted as well as subacromial bursitis. Prior therapies included physical therapy, medications and an IT pump implant. The provider recommended the continued use of ondansetron 8 mg and oxycodone. The provider's rationale was not provided. The Request for Authorization form for ondansetron was dated 01/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ondansetron 8 mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physicians Desk Reference.

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

Decision rationale: The request for ondansetron 8 mg is non-certified. 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 opioids adverse effects include nausea and vomiting and are limited to a 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 would not be indicated. The injured worker has been prescribed ondansetron since at least 12/2013. The efficacy of the medication was not provided. Additionally, the provider's request does not indicate the frequency or quantity of the medication being requested. As such, the request is non-certified.

Oxycodone: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines When to Continue Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Chapter, Opioids.

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

Decision rationale: The request for oxycodone is non-certified. The California MTUS Guidelines recommend the use of opioids for the ongoing management of chronic low back pain. The guidelines recommend that ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should be evident. There is a lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation for risk of aberrant drug abuse behavior and side effects. The injured worker has been prescribed oxycodone since at least 12/2013. The efficacy of the medication was not provided. Additionally, the provider's request for oxycodone does not indicate the dose, frequency or quantity of the request. As such, the request is non-certified.