

<b>Case Number:</b>	CM14-0025070		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	05/18/2011
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2014

### 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 Orthopedic Surgery 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:

The injured worker is a 58 year-old male injured on 5/18/2011. The mechanism of injury is not listed. The claimant underwent left shoulder arthroscopic surgery on 1/30/2013. The most recent progress note dated 4/18/2014, indicates that there are ongoing complaints of neck pain, left shoulder pain and low back pain that radiates to the lower extremities. Physical examination was limited by the patient's lack of effort; he demonstrated a positive Waddell's for evidence of allodynia; axial compression test hurt from the neck to the lumbar spine; JAMAR grip dynamometer: 2/4/2 kg right, 0/0/0 left; straight leg raising was negative at 80 bilaterally; Nonspecific decrease sensation in lower extremities; poor effort on neck, back and right upper extremity range of motion and motor testing. MRI of the cervical spine dated 5/7/2014 showed a small broad based disc protrusion at C5/6 resulting in mild canal stenosis and mild right foraminal narrowing. MRI of left shoulder dated 5/7/2014 showed significant focal rotator cuff tendinosis with possible full thickness tear; partial thickness tears of the subscapularis and confluence of the supraspinatus and infraspinatus footprint fibers, and suspected biceps tendinosis. MRI of the lumbar spine dated 5/7/2014 showed mild left-sided foraminal narrowing at L3/4 and L4/5 due to minimal broad based disc protrusions. EMG/nerve conduction study dated 5/12/2014 reveals evidence of a severe bilateral carpal tunnel syndrome affecting sensory and motor components; and evidence of a mild acute L5 radiculopathy. Previous treatment includes physical therapy, cortisone injections, and medications. A request had been made for Flexeril 7.5 mg #90, Norco 5/325 mg #60 with 2 refills, and Zofran 8 mg #6 with 2 refills on 3/6/2014. The request for Flexeril 7.5 mg and Zofran 8 mg were non-certified; and the request for Norco 5/325 mg was partially certified for #45 to allow for weaning over 4 to 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FLEXERIL 7.5 MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CYCLOBENZAPRINE (FLEXERIL).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41, 64.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines supports the use of Flexeril for a short-term treatment for chronic pain; however, advises against long-term use. Given the claimant's date of injury clinical presentation, the guidelines do not support this request for chronic pain. The request for Flexeril 7.5 mg # 90 is not medically necessary and appropriate.

**NORCO 5/325 #60 WITH 2 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines HYDROCODONE/ACETAMINOPHEN.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-78.

**Decision rationale:** Norco (Hydrocodone/acetaminophen) is a short-acting opioid combined with acetaminophen. The Chronic Pain Medical Treatment Guidelines supports short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no clinical documentation of improvement in their pain or function with the current regimen. As such, the request for Norco 5/325 mg # 60 with two refills is not medically necessary and appropriate.

**ZOFRAN 8MG #6 WITH 2 REFILLS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** Ondansetron (Zofran) is a serotonin 5-HT<sub>3</sub> receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy, radiation treatment, post-operatively, and acute gastroenteritis. The Official Disability Guidelines (ODG) does not recommend this medication for nausea and vomiting secondary to chronic opiate use. Review of the available medical records fails to document an indication for why this medication was given.

As such, the request for Zofran 8 mg # 6 with two refills is not medically necessary and appropriate.