

Case Number:	CM14-0031228		
Date Assigned:	06/20/2014	Date of Injury:	10/17/2011
Decision Date:	07/17/2014	UR Denial Date:	02/17/2014
Priority:	Standard	Application Received:	03/12/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 52-year-old female with a reported date of injury on 10/17/2011. The mechanism of injury was not provided within the clinical information available for review. The injured worker presented with persistent pain in the wrists and residual pain at the elbows. Upon physical examination the injured worker's bilateral elbows revealed well-healed cubital tunnel release scars and pain with terminal flexion. The bilateral wrists revealed well-healed carpal tunnel release scars with tenderness to the volar aspect of the wrists and neurovascular status remains intact. According to the clinical information the injured worker previous participated in physical therapy, the results of which were not provided within the documentation available for review. The injured worker's diagnoses included status post left cubital and carpal tunnel release surgeries, post right carpal and cubital tunnel release with recurrent right carpal tunnel syndrome/double crush and status post revision right carpal tunnel release. Additional diagnoses included essential hypertension and depression. The injured worker's medication regimen included Mobic, lisinopril, atenolol, Flonase, triamcinolone acetonide, Lotrimin topical analgesic, Lisinopril, Pepcid, Loratadine, acetaminophen, Naproxen, Cyclobenzaprine, Sumatriptan succinate, and ondansetron, omeprazole, and tramadol. The Request for Authorization for tramadol hydrochloride ER 150 mg #90 and ondansetron ODT 8 mg #60 was submitted on 03/12/2014. The rationale for the request was not provided within the documentation available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol Hydrochloride ER 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going management Page(s): 78.

Decision rationale: The California MTUS Guidelines state that the ongoing management of opioids should include the ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The clinical documentation provided for review indicates that the injured worker has been utilizing tramadol prior to 09/11/2013. There is a lack of documentation related to the injured worker's pain relief, functional status, appropriate medication use, and side effects. There is a lack of documentation related to the injured worker's previous physical therapy. In addition, the rationale for the request was not provided within the documentation available for review. The clinical information provided for review lacks documentation of the injured worker's functional deficits to include range of motion values. In addition, the request as submitted failed to provide a frequency and directions for use. Therefore, the request for tramadol hydrochloride ER 150 mg #90 is not medically necessary.

Ondansetron ODT Tablets 8mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment of Workers Compensation - Antiemetics (for opioid 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 (for opioid nausea).

Decision rationale: The Official Disability Guidelines state that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is common with use of opioids, the side effects tend to diminish over days to weeks with continued exposure. The opioid adverse effects including nausea and vomiting are limited to short-term duration (less than 4 weeks) and have limited application to long-term use. If nausea and vomiting remains prolonged, other etiologies of these symptoms should be evaluated. In addition, the guidelines state that Ondansetron is approved for nausea and vomiting secondary to chemotherapy and radiation treatment, and acute use is approved for gastroenteritis. According to the clinical information provided for review, the injured worker has utilized Ondansetron prior to 09/11/2013. There is a lack of documentation related to the therapeutic benefit of long-term use of the medication. In addition, the guidelines state that Ondansetron is approved for nausea and vomiting secondary to chemotherapy and radiation treatment, as well as approved for gastroenteritis. The rationale for the request was not provided within the documentation available for review. The clinical information lacks documentation of prior chemotherapy,

radiation, or diagnosis of gastroenteritis. In addition, the request as submitted failed to provide frequency and directions for use. Therefore, the request for Ondansetron ODT 8 mg #60 is not medically necessary.