

Case Number:	CM14-0036427		
Date Assigned:	06/25/2014	Date of Injury:	01/13/2011
Decision Date:	08/12/2014	UR Denial Date:	03/09/2014
Priority:	Standard	Application Received:	03/25/2014

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 New York and Texas. 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 51 year old female injured on 01/13/11 when she tripped and fell on uneven cement resulting in an injury to the right upper extremity. Current diagnoses include right shoulder partial rotator cuff tear and probable underlying superior labrum anterior posterior (SLAP) lesion, nearly resolved adhesive capsulitis with underlying pre-diabetes, a moderate cervical degenerative disc disease, carpal tunnel and cubital tunnel syndrome, potential injuries to the left knee and left ankle, and right DeQuervain's syndrome secondary tendonitis phenomenon. The documentation indicates the injured worker underwent initial right rotator cuff repair in 2001; however, an additional rotator cuff repair and subacromial decompression has been requested. Previous treatment included medications, work restrictions, rest, home exercise program, physical therapy, and injections. The clinical note dated 03/03/14 indicates the injured worker presented complaining of persistent shoulder and neck pain and discomfort. Physical examination revealed non-specific pain about the base of the neck, non-specific pain about the upper trapezius muscle fibers, and positive impingement signs 1 and 2. Recommendations for treatment plan included the injured worker's decision to proceed with shoulder surgery. The injured worker was provided with an ultra-sling. There was no discussion regarding medication management. The initial request for Oxycontin Controlled Release 10mg #20 and Ondansetron 4mg #10 was initially non-certified on 03/09/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin Controlled-Release 10mg #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the Use of Opioids, Therapeutic Trial of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is not discussion in the documentation regarding the initiation or medical necessity of the requested medication. As such, the request of Oxycontin Controlled-Release 10mg #20 is not medically necessary and appropriate.

Ondansetron 4mg #10: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Insert rationale as noted in the Pain Chapter of the Official Disability Guidelines, antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Zofran is Food and Drug Administration (FDA)-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also Food and Drug Administration (FDA)-approved for postoperative use and acute gastroenteritis. There is not discussion in the documentation regarding the initiation or medical necessity of the requested medication. As such, the request for Ondansetron 4mg #10 is not medically necessary and appropriate