

<b>Case Number:</b>	CM14-0038519		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	07/11/2008
<b>Decision Date:</b>	07/31/2014	<b>UR Denial Date:</b>	03/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2014

### 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 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 patient is a female who was injured on 7/11/2008, when she cut by a slicing machine. Sustained full thickness skin avulsions to her right index, third and fourth fingers, and surgeries were performed in 2008 and 2010. She had a Bier block of the right upper extremity on 4/10/2012, for diagnosis of CRPS of right upper extremity. A prior UR determination report dated 3/12/2014 certified follow up treatment in 3 wks, and recommended non-certification for CT of the abdomen, Theramine, Nizatidine, and Ondasetron. According to 2/04/2014 pain management consultation report, the patient is being evaluated for cervical spine pain rated 10/10, when working, heavy sensation in the left shoulder with numbness/tingling in the left. She has weakness, numbness and hypersensitivity and complete loss of use of right hand. She also notes hip/thoracic pain. Her history injuries and treatments, as related by the patient is extensively detailed. Per relevant medical history, she denies heart, kidney, liver, respiratory, or GI complaints; she has no thyroid disease or asthma. Review of systems is normal/negative, except for history of anxiety and trouble sleeping. Per the GI ROS, she has no history of peptic ulcer disease, constipation, diarrhea, or IBS. Current medications include Gabapentin, Endocet, Omeprazole, Elavil, Cymbalta, Lorazepam, Lunesta, and Norco. Examination of the cervical, upper extremities was performed. Diagnoses: 1. Left shoulder internal derangement; 2. Status post traumatic lacerations of nerves and tendons of index, middle and right fingers of right hand; 3. Complex regional pain syndrome; 4. Anxiety and depression. Recommendations for treatment are bier block of right upper extremity, discussed possibly of SCS trial depending on results of bier block, discontinued Endocet because patient feels acetaminophen aggravates her stomach, she is placed on Oxycodone 10mg 2xday, UDS, and re-evaluation following procedure. The 4/29/2014 PR-2 is hand written and very difficult to read. Appears to state the patient had bier block for RUE CRPS on 2/19/2014. She has completed 7 acupuncture sessions. Appears to

indicate symptoms are moderate, frequent with dull/sharp/burning/and numbness. No GI complaints are reported. The rest is illegible. Objective findings appear to include right wrist has slight vasomotor changes and hypersensitive to touch, lumbar has tender paraspinals, SLR, and limited ROM, left wrist tender has positive Tinels.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**CT Scan Abdomen w/o contrast:** 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 Other Medical Treatment Guideline or Medical Evidence: American College of Radiology [http://www.acr.org/~media/ACR/Documents/PGTS/guidelines/CT\\_Abdomen\\_Pelvis.pdf](http://www.acr.org/~media/ACR/Documents/PGTS/guidelines/CT_Abdomen_Pelvis.pdf).

**Decision rationale:** CA MTUS and ODG do not discuss the issue in dispute. According to the American College of Radiology, INDICATIONS AND CONTRAINDICATIONS A. Indications for abdominal CT or pelvic CT examinations include, but are not limited to: 1. Evaluation of abdominal, flank, or pelvic pain, including evaluation of suspected or known urinary calculi [1-3] and appendicitis [4-6]. 2. Evaluation of renal and adrenal masses and of urinary tract abnormalities with CT urography [7-10]. 3. Evaluation of known or suspected abdominal or pelvic masses or fluid collections, including gynecological masses [11-13]. 4. Evaluation of primary or metastatic malignancies, including lesion characterization, e.g., focal liver lesion [14-17]. 5. Evaluation of diffuse liver disease (e.g., steatosis, iron deposition disease, cirrhosis [18-19]) and biliary system, including CT cholangiography [20]. 6. Assessment for recurrence of tumors following surgical resection [21-22]. 7. Detection of complications following abdominal and pelvic surgery, e.g., abscess, lymphocele, radiation change, and fistula/sinus tract formation [23-26]. 8. Evaluation of abdominal or pelvic inflammatory processes, including inflammatory bowel disease, infectious bowel disease and its complications, without or with CT enterography [27-29]. 9. Assessment of abnormalities of abdominal or pelvic vascular structures [30-32]. 10. Evaluation of abdominal or pelvic trauma [33-36]. 11. Clarification of findings from other imaging studies or laboratory abnormalities. 12. Evaluation of known or suspected congenital abnormalities of abdominal or pelvic organs [37-38]. 13. Evaluation for small bowel or large bowel obstruction [39-40]. 14. Screening for colonic polyps and cancers with CT colonography [41-42]. 15. Guidance for interventional or therapeutic procedures within the abdomen or pelvis [43-45]. 16. Treatment planning for radiation and chemotherapy and evaluation of tumor response to treatment, including perfusion studies [46-50]. 17. Pre- and post-transplant assessment [51-52]. 18. Noninvasive angiography of the aorta and its branches and noninvasive venography [53-54]. This patient is noted to have prior history of GI complaints/symptoms related medication use. Changes have been made to her medication regimen. There is no evidence of significant change or worsening of GI symptoms or evidence of potential red flag diagnosis in the recent medical records. Furthermore, based on her documented medical history,

subjective complaints and objective findings, this patient does not have any of the indications, as outlined by the ACR, for proceeding with CT of abdomen. The request is not medically necessary.

**Theramine #90:** Upheld

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

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

**Decision rationale:** CA MTUS guidelines do not discuss the issue in dispute. As per ODG, Theramine, a medical food proprietary blend of gamma-aminobutyric acid [GABA] and Choline Bitartrate, L-Arginine, and L-Serine. According to the guidelines, Theramine is not recommended. It is noted in the literature that there is no high quality peer-reviewed literature that suggests that GABA is indicated, and there is no known medical need for Choline supplementation. The product is not supported by the evidence-based medical literature; the medically necessary of Theramine is not established.

**Nizatidine #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.rxlist.com/axid-drug/indications-dosafe.htm>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medline Plus: Nizatidine (Axid) <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a694030.html>.

**Decision rationale:** CA MTUS and ODG do not discuss the issue in dispute. According to the medical literature, Nizatidine (Axid) is used to treat and prevent the recurrence of ulcers and to treat other conditions where the stomach makes too much acid. It decreases the amount of acid made in the stomach. The medical records do not establish prior history of ulcers, nor current findings indicating prevention of recurrence of ulcers. The guidelines recommend for patients found to have intermediate to high risk of GI events, then a non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or Misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. The medical records do not establish Nizatidine is appropriate and medically necessary in this case.

**Ondasetron 8 mg #10:** 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), Chapter, Pain.

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

**Decision rationale:** CA MTUS do not discuss the issue in dispute. According to the Official Disability Guidelines, Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use. This medication is recommended for acute use as noted, per FDA-approved indications. Ondansetron is a serotonin 5-HT<sub>3</sub> receptor antagonist that is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also approved for postoperative use and acute use is FDA-approved for gastroenteritis. Chronic use of this medication is not recommended. The medical records do not establish the patient presents with any of the conditions this medication is approved to treat. The medical records do not establish Ondansetron is medically necessary in this case.