

<b>Case Number:</b>	CM14-0079424		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	08/01/2012
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	05/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2014

### 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 Family Medicine 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:

This is a 40 year old male patient who reported an industrial injury on 8/1/2012, over two (2) years ago, attributed to the performance of his customary job tasks. The patient complained of pain in the neck and back. The patient also reported having visual disturbances with focus issues. The patient complained of hip pain. The objective findings on examination included, positive tenderness to palpation in the paralumbar musculature; positive muscle spasms in the paralumbar musculature; normal DTRs; range of motion of the lumbar spine was diminished; positive SLR to the bilateral lower extremities; diminished sensation L4, L5, and S1 nerve root distribution; tenderness over the greater trochanteric bursa; range of motion the hip was documented as diminished. The diagnoses included chronic intractable lower back pain, degenerative disc disease lumbar spine, disc herniation lumbar spine, radiculitis bilateral lower extremities, left lower extremity L4, L5, and S1 neuropathic pain, greater trochanteric bursitis to the bilateral hips, and depression. The patient was prescribed and dispensed cyclobenzaprine #90; diclofenac XR hundred milligrams #60; omeprazole 20 mg #60; tramadol ER 150 mg #60. The patient was prescribed Wellbutrin 150 mg #30 and ondansetron 4 mg #30 directed to nausea.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Wellbutrin 150mg, po qd, #30 for depression neuropathic pain refill #0: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 16. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines-Antidepressants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs ;tri cyclic antidepressants Page(s): 107; 15. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-- antidepressants for chronic pain; Fluoxetine.

**Decision rationale:** The patient is being treated for anxiety and depression, which has been ongoing with Wellbutrin (Bupropion) 150 mg #30; however, there is no provided nexus with the industrial injury for the stated depression other than the issues of chronic pain. The use of Wellbutrin (Bupropion) is not demonstrated to be medically necessary for the treatment of depression as an effect of the industrial injury. There is no objective evidence to support the medical necessity of the prescribed antidepressants. There is no clinical documentation of efficacy or any functional improvement with the use of the dispensed antidepressants. There is no mental status assessment or review for the efficacy of the prescribed Wellbutrin (Bupropion). There is no documented functional improvement with the prescribed Wellbutrin. The use of the antidepressant is consistent with the treatment of chronic pain; however, the patient has very few objective findings documented in his extensive medical records to support ongoing pain issues related to chronic pain. The patient has no specific etiology of the perceived chronic pain issues related to depression. The depression is not clearly demonstrated to be the result of chronic pain or the ongoing treatment of chronic pain. There are no functional assessments of the stated depression and anxiety to demonstrate functional improvement with Wellbutrin (Bupropion). The use of the medication is not demonstrated to lead to functional improvement in the provided medical records. There is no documented functional improvement attributed to the prescription of Wellbutrin (Bupropion). There is no demonstrated medical necessity for the continued dispensing of Wellbutrin (Bupropion) for this patient. The prescription of refills is excessive and does not allow for functional assessments and between the requested refills. There was no demonstrated trial with TCAs prior to the use of Wellbutrin (Bupropion). The request is not medically necessary and appropriate.

**Ondansetron 4 mg p.o. qd, #30 to counter effect nausea refill #0:** Upheld

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

**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: General disciplinary guidelines for the practice of medicine.

**Decision rationale:** The treating provider provided no objective evidence to support the medical necessity of the prescribed Zofran/Ondansetron for nausea or vomiting reportedly due to chronic pain and headaches. The prescription of Ondansetron for episodes of nausea and vomiting allegedly due to the side effects of medications or chronic pain is not supported with objective evidence. Zofran is typically prescribed for the nausea and vomiting associated with

chemotherapy and is not medically necessary for nausea suggested to be caused by medication side effects prescribed for the course of treatment. There is no documentation of any medications caused such side effects or the use of typical generic medications generally prescribed for nausea or vomiting. The prescription was provided without objective evidence of medication side effects or any relation to the effects of the industrial injury. There is no documentation of the failure of more common anti-emetics. The prescription of Zofran is recommended only for the nausea and vomiting associated with chemotherapy and is not FDA approved for the use of general nausea secondary to medications or from chronic pain. The use of the Zofran for the effects of the industrial injury is not supported with objective evidence that demonstrates medical necessity over conventionally prescribed anti-emetics. The patient is being prescribed Ondansetron for an off label purpose and does not meet the criteria recommended for the use of the anti-nausea medications developed for chemotherapy side effects. There is no demonstrated medical necessity for the prescribed ondansetron 4 mg #30. Zofran: (Ondansetron) is a serotonin 5-HT<sub>3</sub> receptor antagonist: used mainly as an antiemetic to treat nausea and vomiting, often following chemotherapy. Its effects are thought to be on both peripheral and central nerves. Ondansetron reduces the activity of the vagus nerve, which deactivates the vomiting center in the medulla oblongata, and also blocks serotonin receptors in the chemoreceptor trigger zone. It has little effect on vomiting caused by motion sickness, and does not have any effect on dopamine receptors or muscarinic receptors. The request is not medically necessary and appropriate.