

<b>Case Number:</b>	CM14-0082856		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	03/04/1997
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	05/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2014

### 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 Texas and Ohio. 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 59-year-old female with a reported date of injury on 03/04/1997 due to a motor vehicle accident. The injured worker was diagnosed with chronic pain syndrome, torticollis unspecified, adjustment disorder with disturbance of conduct, conductive hearing loss bilaterally, and acute mucoid otitis media. Prior treatments included 5 psychiatric sessions and 8 Botox injections in 2001, and an occipital nerve block. Previously, the injured worker underwent right foot surgeries in 2008 and 2010. The injured worker saw her provider on 12/12/2013 and reported pain to her neck that radiated into the back of the head associated with torticollis, which was subsiding. The injured worker reported pain was rated 6-7/10 at worst and 2/10 at best. She stated her pain was rated 4-6/10 on average. The physician noted an improvement in left lateral rotation from 15 degrees to 30 degrees and an improvement in right lateral rotation from nearly 0 to 15 degrees. The physician noted a urine drug screen was negative for illicit drugs. The clinical note dated 04/22/2014 noted the injured worker complained of headache pain, mostly to the right side of her head, rated 9/10 and ear pain. She complained of having a very tender feeling scalp with the headache and difficulty controlling the movement of her head and neck. The injured worker suffered constantly from a stiff neck and pain with moving her neck. Tremors were noted when she extended her head backward. The injured worker was prescribed Percocet, Klonopin, ondansetron, and pantoprazole sodium. The physician's treatment plan was to consider the injured worker's request for future Botox injections continue with medications. The Request for Authorization form and rationale were not provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 Qty 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain Chapter.

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

**Decision rationale:** The California MTUS guidelines recommend ongoing review with documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The guidelines also recommend providers assess for side effects and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. The injured worker has been prescribed Percocet since at least 12/12/2013. The physician has monitored for aberrant drug taking behaviors and utilized urine drug screening. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. An adequate and complete pain assessment is not provided within the medical records. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request is not medically necessary.

**Klonopin 1mg Qty 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The California MTUS guidelines note benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence; most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. The injured worker has been prescribed this medication since at least 12/12/2013. The continued use of this medication would exceed the guideline recommendation for a short course of treatment. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request is not medically necessary.

**Ondansetron 8mg Qty 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain Chapter.

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

**Decision rationale:** The Official Disability Guidelines note antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. The guidelines recommend Ondansetron for nausea and vomiting secondary to chemotherapy and radiation treatment, for postoperative use, as well as acute use for gastroenteritis. There is a lack of documentation indicating the injured worker has significant nausea and vomiting due to gastritis for which medication would be indicated. There is no documentation indicating the injured worker is undergoing chemotherapy or radiation. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request is not medically necessary.