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| Case Number: | CM14-0186842 | | |
| Date Assigned: | 11/14/2014 | Date of Injury: | 09/14/2010 |
| Decision Date: | 01/14/2015 | UR Denial Date: | 11/10/2014 |
| Priority: | Standard | Application Received: | 11/10/2014 |

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 Anesthesia, has a subspecialty in Acupuncture & Pain 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:

44y/o female injured worker with date of injury 7/31/99 with related back and right knee pain. Per progress report dated 8/19/14, the injured worker stated that she has been having worsening back pain, and worsening neck pain that radiates down her left arm. She rated her back pain 9/10, right knee pain 8/10, and neck pain 8/10 in intensity. Per physical exam, straight leg raise test was positive bilaterally, deep tendon reflexes were +1 at the knees and ankles, strength was 5/5 in the lower extremity muscle groups. Cervical compression caused neck pain that radiated into the left shoulder blade area. She reported altered sensory loss to light touch and pinprick along the dorsum of the left forearm. Deep tendon reflexes in the upper extremities were +1 at the biceps, triceps, and brachioradialis with 5/5 strength in the upper extremity muscle groups tested. The documentation submitted for review did not state whether physical therapy was utilized. Treatment to date has included medication management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg, #30 with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78,91.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding ongoing management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. These domains have been summarized as the '4s' (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Review of the documentation submitted for review supports the ongoing use of Norco. Per the latest progress report dated 8/19/14, it was noted that the injured worker reported 50% reduction in her pain and 50% functional improvement with activities of daily living. She was under a narcotic contract and urine drug screens had been appropriate. However, as the request is for a 3 month supply, it does not allow for timely ongoing reassessment of medication efficacy. As such the request is not medically necessary.

Paxil 20 mg, #30 with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 16.

Decision rationale: Per MTUS CPMTG with regard to the use of antidepressants for chronic pain: "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006). The latest progress report available for review dated 8/19/14 did not contain findings consistent with neuropathic pain. As the requested medication is not indicated, the request is not medically necessary. It was noted per 7/3/14 progress report that the injured worker used Effexor 37.5mg daily for bipolar depression. Therefore the request is not medically necessary.

Ondansetron 4 mg, #90: 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

Decision rationale: The MTUS is silent on the use of ondansetron. With regard to antiemetics, the ODG states "Not recommended for nausea and vomiting secondary to chronic opioid use. Recommended for acute use as noted below per FDA-approved indications." Specifically, "Ondansetron (Zofran): This drug is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-

approved for postoperative use. Acute use is FDA-approved for gastroenteritis." As the injured worker is not postoperative or experiencing nausea and vomiting secondary to chemotherapy and radiation treatment, or gastroenteritis, ondansetron is not recommended. There was no documentation suggesting the ongoing necessity of the medication or its efficacy. The request is not medically necessary.