

Case Number:	CM14-0196519		
Date Assigned:	12/04/2014	Date of Injury:	04/21/2014
Decision Date:	01/21/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/24/2014

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 Practice 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 61 year old female injures worker who sustained a work related injury on 4/21/14. Injured worker sustained the injury when she fell at work after trying to sit in a chair that broke and fell onto the cement striking her knee, shoulder, neck, back and right wrist. The current diagnoses include tendinitis of wrist, right wrist tendinitis at the fourth dorsal compartment and right wrist tendinitis at the sixth dorsal compartment per the doctor's note dated 10/21/14; injured worker has complaints of right wrist pain. Physical examination of the of right wrist revealed tenderness to palpation on the dorsal aspect of the wrist worse with resisted wrist extension and with passive wrist flexion, pain with active ulnar deviation and with passive radial deviation, Foveal sign was positive with slight pain with deep palpation. The current medication lists include Zofran, Ibuprofen, Hydrochlorothiazide, Levoxyl Hydrocodone and Colace. The patient has had MRI of the right shoulder on 8/21/14 that revealed no significant corticomedullary structural or bone marrow abnormalities; X-rays of the right knee on 10/19/14 that revealed no evidence of fractures or dislocations. She had received right knee cortisone injection for this injury. The injured worker has received 24 PT visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 600mg 1 po TID #90: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: Ibuprofen belongs to a group of drugs called nonsteroidal anti-inflammatory drugs (NSAIDs). According to CA MTUS, Chronic pain medical treatment guidelines, "Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. (Van Tulder-Cochrane, 2000)." The injured worker is having chronic pain and is taking ibuprofen for this injury. Per the doctor's note dated 10/21/14, injured worker has complaints of right wrist pain and physical examination of the of right wrist revealed tenderness to palpation on the dorsal aspect of the wrist worse with resisted wrist extension and with passive wrist flexion, pain with active ulnar deviation and with passive radial deviation, Foveal sign was positive with slight pain with deep palpation. NSAIDS like Ibuprofen are first line treatments to reduce pain. The request for Ibuprofen 600mg 1 po TID #90 is medically necessary.

Colace 100mg one cap po BID #10: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chapter: Pain, Opioid induced constipation treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Thompson Micromedex; FDA labeled indication for Docusate sodium Constipation care

Decision rationale: ACOEM/CA MTUS do not address this request. Colace contains Docusate sodium. According to the Thompson Micromedex FDA labeled indication for Colace includes "constipation care." As per records provided the injured worker is taking narcotics, which can cause constipation. Therefore, the request for Colace 100mg one cap po BID #10 is medically necessary.

Zofran 4mg 1 po every 4-6 hours PRN #10: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (updated 11/21/14) Antiemetics (for opioid nausea) Thompson micromedex; Ondansetron; FDA labeled indication

Decision rationale: Ondansetron is 5-HT3 receptor antagonist which acts as anti-emetic drug. CA MTUS/ACOEM does not address this request. Therefore ODG and Thompson Micromedex were used. Per ODG, "Antiemetics (for opioid nausea), Not recommended for nausea and vomiting secondary to chronic opioid use." According to the Thompson micromedex guidelines,

FDA labeled indications for Ondansetron include, "Chemotherapy-induced nausea and vomiting, highly emetogenic chemotherapy; Prophylaxis; Chemotherapy-induced nausea and vomiting, moderately emetogenic chemotherapy; Prophylaxis; Postoperative nausea and vomiting; Prophylaxis and Radiation-induced nausea and vomiting; Prophylaxis." Any indication listed above was not specified in the records provided. A rationale for use of this medication was not specified in the records provided. Any abnormal findings on GI examination were not specified in the records provided. The clinical information submitted for this review does not establish the medical necessity of the Zofran 4mg 1 po every 4-6 hours PRN #10 for this patient at this juncture. Therefore the request is not medically necessary.