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| <b>Case Number:</b>   | CM15-0004451 |                              |            |
| <b>Date Assigned:</b> | 01/26/2015   | <b>Date of Injury:</b>       | 03/18/2009 |
| <b>Decision Date:</b> | 03/13/2015   | <b>UR Denial Date:</b>       | 12/18/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/08/2015 |

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: California  
Certification(s)/Specialty: Emergency Medicine

### 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 45 year old male, who sustained an industrial injury on March 18, 2009. He has reported an injury to the right shoulder. The diagnoses have included pain in the shoulder joint, arthropathy, and shoulder bursas. Treatment to date has included pain medication, TENS unit, cognitive behavioral therapy, home exercise program and right shoulder chondroplasty and debridement surgery. Currently, the injured worker complains of persistent right shoulder pain which is severe and constant. The pain has been described as burning, sharp, dull, aching, cutting, throbbing and shooting pain. He reports pain when he lifts and raises the arm. On examination, the injured worker's movements are restricted with flexion, extension and abduction. The injured worker is currently taking Norco, Lidoderm and Menthoderm Gel for pain. The objective functional improvement related to take the medication regimen was not established. On December 18, 2014 Utilization Review non-certified a request for Zofran ODI 8 mg, Norco 10-325/mg #150 and Cyclobenzaprine/Flexeril 5 mg #30, noting that the documentation did not establish that the injured worker had been treated with "Y" drugs; the documentation did not provide evidence of significant improvement in pain or a percent improvement associated with chronic use of Norco; and there is no documentation of significant and progressive improvement in function associated with chronic daily use of the medication. The California Medical Treatment Utilization Schedule has been cited. On January 8, 2015, the injured worker submitted an application for IMR for review of Zofran ODI 8 mg, Norco 10-325/mg #150 and Cyclobenzaprine/Flexeril 5 mg #30.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Zofran ODT 8 mg (unspecified): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain (Chronic), Ondansetron (Zofran®)

**Decision rationale:** The requested Zofran ODT 8 mg (unspecified) is not medically necessary. CA MTUS 2009 ACOEM is silent on this issue. ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Pain (Chronic), Ondansetron (Zofran), note "Not recommended for nausea and vomiting secondary to chronic opioid use." The injured worker has persistent right shoulder pain which is severe and constant. The pain has been described as burning, sharp, dull, aching, cutting, throbbing and shooting pain. He reports pain when he lifts and raises the arm. The treating physician has documented that the injured worker's movements are restricted with flexion, extension and abduction. The treating physician has not documented symptoms of nausea and vomiting, duration of treatment, nor derived functional improvement from its use. The criteria noted above not having been met, Zofran ODT 8 mg (unspecified) is not medically necessary.

**Norco 10/325 mg #150: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): Page 7.

**Decision rationale:** The requested Norco 10/325 mg #150 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has persistent right shoulder pain which is severe and constant. The pain has been described as burning, sharp, dull, aching, cutting, throbbing and shooting pain. He reports pain when he lifts and raises the arm. The treating physician has documented that the injured worker's movements are restricted with flexion, extension and abduction. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Norco 10/325 mg #150 is not medically necessary.

**Cyclobenzaprine/Flexeril 5 mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page 63-66.

**Decision rationale:** The requested Cyclobenzaprine/Flexeril 5 mg #30 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants, Page 63-66, do not recommend muscle relaxants as more efficacious than NSAIDs and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has persistent right shoulder pain which is severe and constant. The pain has been described as burning, sharp, dull, aching, cutting, throbbing and shooting pain. He reports pain when he lifts and raises the arm. The treating physician has documented that the injured worker's movements are restricted with flexion, extension and abduction. The treating physician has not documented spasticity or hypertonicity on exam, intolerance to NSAID treatment, nor objective evidence of derived functional improvement from its previous use. The criteria noted above not having been met, Cyclobenzaprine/Flexeril 5 mg #30 is not medically necessary.