

Case Number:	CM15-0145703		
Date Assigned:	08/11/2015	Date of Injury:	07/24/2011
Decision Date:	09/14/2015	UR Denial Date:	07/07/2015
Priority:	Standard	Application Received:	07/27/2015

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: Physical Medicine & Rehabilitation

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 44 year-old female who sustained an industrial injury on 07-24-11. She reported right shoulder pain. Initial diagnosis is not available. Prior treatments included right shoulder arthroscopic subacromial decompression and AC joint resection. Current diagnoses include disorders of bursae and tendons in shoulder region unspecified. Diagnostic testing and treatment to date has included radiographic imaging, physical therapy, acupuncture, and symptomatic medication management to include steroid therapy. In a progress note dated 06-26-15, the treating physician reports the injured worker is doing markedly better with close to 90% improvement of her right shoulder. The injured worker states she has been overusing her left shoulder as compensatory and as a consequence, she has increased pain in the left shoulder. The injured worker complains of right shoulder pain and moderate to severe neck pain. Requested treatments include physical therapy for the cervical spine, and 3 x 6, Ondansetron 4 mg #30. The injured worker's status is reported as permanent and stationary. Date of Utilization Review: 07-07-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the cervical spine, 3 x 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: The patient presents on 06/26/15 with 90 percent improvement in her right shoulder pain, recent emergence of compensatory left shoulder pain, and unrated moderate-to-severe neck pain well controlled with current medications. The patient's date of injury is 07/24/11. Patient is status post right shoulder subacromial decompression and AC joint resection at a date unspecified. The request is for PHYSICAL THERAPY FOR THE CERVICAL SPINE, 3 X 6. The RFA was not provided. Physical examination dated 06/26/15 reveals tenderness to palpation of the paralumbar musculature, posterior illiac spine, left greater humeral tuberosity, medial epicondyle and antecubital fossa of the right elbow, patellofemoral facet of the bilateral knee joints. The provider also notes positive crepitus in the left shoulder and diminished sensation along the right L4 and L5 nerve distributions. The patient is currently prescribed Diclofenac, Omeprazole, and Ondansetron. Diagnostic imaging was not provided. Patient is currently classified as permanent and stationary. MTUS Chronic Pain Medical Treatment Guidelines, pages 98 to 99 state that for patients with "myalgia and myositis, 9 to 10 sessions over 8 weeks are allowed, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits over 4 weeks are allowed." In regard to the request for an additional 18 sessions of physical therapy directed at this patient's neck pain, the provider has exceeded guideline criteria. There is no indication in the documentation provided that this patient has recently undergone any physical therapy treatments. MTUS guidelines support up to 10 visits for complaints of this nature, the request for 18 sessions exceeds these recommendations. There is no rationale provided as to why this patient is unable to transition to self-directed physical therapy at home, either. Therefore, this request IS NOT medically necessary.

Ondansetron 4mg #30: Upheld

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

Decision rationale: The patient presents on 06/26/15 with 90 percent improvement in her right shoulder pain, recent emergence of compensatory left shoulder pain, and unrated moderate-to-severe neck pain well controlled with current medications. The patient's date of injury is 07/24/11. Patient is status post right shoulder subacromial decompression and AC joint resection at a date unspecified. The request is for ONDANSETRON 4MG #30. The RFA was not provided. Physical examination dated 06/26/15 reveals tenderness to palpation of the paralumbar musculature, posterior illiac spine, left greater humeral tuberosity, medial epicondyle and antecubital fossa of the right elbow, patellofemoral facet of the bilateral knee joints. The provider

also notes positive crepitus in the left shoulder and diminished sensation along the right L4 and L5 nerve distributions. The patient is currently prescribed Diclofenac, Omeprazole, and Ondansetron. Diagnostic imaging was not provided. Patient is currently classified as permanent and stationary. MTUS guidelines are silent on antiemetic medications, though ODG guidelines have the following regarding antiemetics: "ODG Guidelines, Pain (Chronic) chapter, Antiemetics (for opioid nausea): Not recommended for nausea and vomiting secondary to chronic opioid use. 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." In regard to Zofran for this patient's nausea secondary to NSAID use, the requesting physician has not provided subjective complaints, pertinent examination findings, or discussion of efficacy to substantiate continued use. This patient has been prescribed Zofran since at least 03/13/15. Per 06/26/15 and 03/13/15 progress notes, Zofran is being prescribed to "counter effect nausea from NSAIDS prophylaxis." However, the provider does not provide a pertinent GI examination at initiation, nor address efficacy in the subsequent reports. Furthermore, medications such as Zofran are only indicated for nausea secondary to chemotherapy, acute gastroenteritis, or acute post-surgical nausea; conditions which this patient does not present with. Therefore, the request IS NOT medically necessary.