

<b>Case Number:</b>	CM15-0024907		
<b>Date Assigned:</b>	02/17/2015	<b>Date of Injury:</b>	07/27/2011
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/09/2015

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

### 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 28 year old male who sustained a work related injury July 27, 2011. Past history included cervical disc arthroplasty 11/21/2014. According to a physician's office visit, dated January 7, 2015, the injured worker presented with neck pain 1-6/10 compared to pre-operative pain of 3-8/10. Although instructed to remove the soft foam collar 7-10 days post-op, he continues to use the collar while sleeping, driving, and to avoid sunlight on the incision. Current medications include Oxycodone, Pristiq, Lexapro, and Trazodone. Examination of the cervical spine reveals the anterior left neck transverse incision is healing; range of motion was full except slightly decreased right lateral flexion and rotation. Assessment included intervertebral cervical disc disorder with myelopathy, cervical spondylosis with myelopathy, spinal stenosis in the cervical region, generalized anxiety/depressive disorder, alcoholism, hypertension, lesion of ulnar nerve and carpal tunnel syndrome. Treatment included referral to physical therapy, x-rays, and medications. According to utilization review dated January 9, 2015, the request for Clonidine 0.1mg (1) Tab PO TID #60 Refills: (3) has been modified to Clonidine 0.1mg (1) Tab PO TID #60 Refills: (1), citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Ondansetron 8mg (1) Tab PO Daily #30 Refills: (1) has been modified to Ondansetron 8mg (1) Tab PO Daily # 30, citing Official Disability Guidelines-TWC.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Clonidine 0.1mg, 1 tablet by mouth, three (3) times per day #60 with 3 refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Clonidine, Intrathecal. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Antiemetic (for opioid nausea)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96. Decision based on Non-MTUS Citation Pain, Weaning, opioids (specific guidelines)

**Decision rationale:** ODG states "Clonidine can relieve many opioid withdrawal symptoms (an off-label treatment) as long as there are no contraindications to use. Dose is generally 0.1-0.2 t.i.d. to q.i.d as long as blood pressure is over 90 mm Hg systolic and there is no sedation or bradycardia. Clonidine is often maintained for 2-3 days after cessation of opioids and tapered over 5-10 days." The treating physician is attempting to wean the patient from opioids on an outpatient basis. As such, the request for Clonidine is medically necessary.

**Ondansetron 8mg, q tablet by mouth daily #30 with 1 refill:** 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), Ondansetron (Zofran) and on the Non-MTUS website, <http://www.amco.org/data/imco/S14-S21.pdf>

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain, Antiemetics (for opioid nausea)

**Decision rationale:** Ondansetron (Zofran) is an antiemetic used to decrease nausea and vomiting. Nausea is a known side effect of chronic opioid use and some Serotonin norepinephrine reuptake inhibitors (SNRIs). ODG does not recommend use of antiemetic for nausea and vomiting secondary to chronic opioid use. Additionally, this drug is a serotonin 5-HT<sub>3</sub> receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. There is no evidence that patient is undergoing chemotherapy/radiation treatment or postoperative. The treating physician (6/11/2013) does write in my opinion his abdominal pain may be due to his long term use of NSAIDs. The treating physician indicates that the patient is on ibuprofen 600mg three times daily. MTUS is specific regarding the gastrointestinal symptoms related to NSAID usage. If criteria are met, the first line treatment is to discontinue usage of NSAID, switch NSAID, or consider usage of proton pump inhibitor. There is no documentation provided that indicated the discontinuation of NSAID or switching of NSAID occurred. Additionally, ondansetron is not a proton pump inhibitor and is not considered first line treatment. As such the request for Ondansetron 8mg, q tablet by mouth daily #30 with 1 refill is not medically indicated.

