

Case Number:	CM15-0216033		
Date Assigned:	11/05/2015	Date of Injury:	06/12/2010
Decision Date:	12/18/2015	UR Denial Date:	10/30/2015
Priority:	Standard	Application Received:	11/02/2015

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: New Jersey

Certification(s)/Specialty: Family Practice

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 31 year old female injured worker suffered an industrial injury on 6-12-2010. The diagnoses included cervical degenerative disc disease, cervical radiculitis, chronic neck pain and perioperative anxiety. On 4-28-2015 the provider reported she presented for a cervical epidural steroid injection with pain in the neck that extended to the upper extremities. The provider reported the clinical symptoms and diagnostic studies were suggestive of cervical discogenic and radicular cause of the pain. The medical record did not indicate rationale for either of the requested treatments. The documentation provided did not include evidence of a comprehensive pain evaluation with pain levels with and without medications, no evidence of functional performance and no aberrant risk assessment. Diagnostics included urine drug screen 3-25-2015 was consistent. Utilization Review on 10-30-2015 determined non-certification Retro Ondansetron ODT 8 MG #10 DOS 4-28-15 and Retro Hydrocodone/APAP 10/325 MG #20 DOS 4-28-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Ondansetron ODT 8 MG #10 DOS 4/28/15: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Anti- emetic use for opioid-related nausea, Zofran.

Decision rationale: The MTUS is silent on the use of Zofran. The ODG states that ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use and is only approved for use in chemo-therapy induced pain or malignancy-induced pain. Antiemetics in general, as also stated in the ODG, are not recommended for nausea related to chronic opioid use, but may be used for acute short-term use (less than 4 weeks) as they have limited application for long term use. Nausea tends to diminish over time with chronic opioid use, but if nausea remains prolonged, other etiologies for the nausea must be evaluated for. Also there is no high quality literature to support any one treatment for opioid-induced nausea in chronic non- malignant pain patients. In the case of this worker #10 pills of ondansetron 8 mg was prescribed to the worker on the same day of a cervical epidural injection (4/28/15). There was no explanation seen in the documentation as to why this was prescribed to the worker. If nausea was expected to follow the injection then a short course of an anti-emetic would be warranted. However, since ondansetron is not a first-line anti-emetic, this would not be medically necessary. This also applies to the possibility of this request being to treat occasional nausea related to opioid use. Therefore, this request for ondansetron will be considered medically unnecessary.

Retro Hydrocodone/APAP 10/325 MG #20 DOS 4/28/15: 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 Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, long-term assessment.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that opioids may be considered for moderate to severe chronic pain as a secondary treatment, but require that for continued opioid use, there is to be ongoing review and documentation of pain relief, functional status, appropriate medication use with implementation of a signed opioid contract, drug screening (when appropriate), review of non-opioid means of pain control, using the lowest possible dose, making sure prescriptions are from a single practitioner and pharmacy, and side effects, as well as consultation with pain specialist if after 3 months unsuccessful with opioid use, all in order to improve function as criteria necessary to support the medical necessity of opioids. Long-term use and continuation of opioids requires this comprehensive review with documentation to justify continuation. In the case of this worker, Norco was prescribed and used chronically leading up to this request for renewal. Upon review of the recent notes provided, there was mention of pain level reduction from "medications," however, no mention of how effective Norco was at reducing pain and improving function, measurably and independently of the other medications used. This would have helped to justify this request. Without this more clear supportive information, this request for hydrocodone/APAP will be considered medically unnecessary at this time. Weaning may be indicated.