

Case Number:	CM14-0093561		
Date Assigned:	07/25/2014	Date of Injury:	03/16/2011
Decision Date:	09/25/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	06/20/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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:

The records presented for review, indicate that this 59-year-old individual was reportedly injured on March 16, 2011. The mechanism of injury was noted as a slip and fall. The most recent progress note, dated April 22, 2014, indicated that there were ongoing complaints of neck, low back, right shoulder, knees, and wrists pains. The physical examination demonstrated increasing range of motion with no significant neurological deficits in the upper extremities. Right shoulder exam noted tenderness at the anterior GH region and subacromial space with a positive Hawkin's test and impingement sign. There was 4/5 strength of rotator cuff function that was documented. Bilateral upper extremities exam revealed dysesthesias of the digits and pain with terminal flexion. Examination of the lumbar spine revealed tenderness of the lumbar paravertebral muscles with spasm and with pain noted at terminal motion. A seated nerve root test was positive. Bilateral knee examination revealed tenderness in the anterior joint line with no signs of instability. Anterior drawer test and posterior pivot shift tests were negative. Some crepitus was noted with painful motion. Diagnostic imaging studies objectified implantation of cervical spine hardware from C4 to C7 with solid incorporation of bone graft at C5 through C7 and total disc replacement of C4-C5. Conventional radiographs of the lumbar spine including flexion and extension views revealed what "appeared to be some hypermobility with spondylosis." No measurements were documented. Prior treatment has included surgical intervention, injections, physical therapy, and activity modifications. A request had been made for ondansetron, sumatriptan succinate, and terocin patch and was not certified in the pre-authorization process on June 11, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ondansetron 8mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC - ODG Treatment, Integrated Treatment/Disability Duration Guidelines; Pain (Chronic); Antiemetic - (updated 09/10/14).

Decision rationale: MTUS/ACOEM does not address this medication. Therefore, ODG guidelines are used. Ondansetron (Zofran) is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy, radiation treatment, post-operatively, and acute gastroenteritis. The ODG guidelines do not recommend this medication for nausea and vomiting secondary to chronic opiate use. Review, of the available medical records, fails to document the utility of this medication or any history of chemotherapy, radiation treatment, a recently postoperative environment, or acute gastroenteritis. In the absence of documentation of the diagnosis, whose treatment is supported by the guidelines, this request would be considered not medically necessary. It should also be noted that the guidelines specifically indicate that ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Based on the medical record available, this request is not medically necessary.

Sumatriptan Succinate: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA: (Sumatriptan Succinate).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Head (trauma, headaches, etc., not including stress and mental disorders) (updated 06/09/14): Imitrex (sumatriptan).

Decision rationale: CA MTUS and ACOEM does not address this medication. Therefore, ODG guidelines are used. Sumatriptan belongs to the triptan class of medications used to treat migraine headaches. The activity is based on an agonist effect on the serotonin 5 HT receptors causing a vasoconstriction, inhibiting the release of inflammatory mediators. The evidence-based guideline recommendations for the use of this medication is specifically for a diagnosis of migraine headache. The progress note, accompanying this request does not include a diagnosis of migraine headache, nor is there adequate documentation that such headaches are related to the industrial injury. In the absence of documentation of a compensable diagnosis that is supported by the guidelines for the treatment requested, this request is not medically necessary.

Terocin patch #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Terocin is a topical analgesic formula containing methyl salicylate 25%, capsaicin 0.025%, menthol 10%, and lidocaine 2.50%. Guideline recommendations note that using a compound medication, that contains at least one drug, that is not recommended, makes the overall utilization not recommended. When noting that neither lidocaine nor menthol is endorsed by the California MTUS for any of this claimant's compensable diagnoses, then an ingredient is not necessary and that makes the entire product not medically necessary. Furthermore, the guidelines supported use of topical lidocaine is recommended only for localized peripheral pain after failure of a trial of first-line therapy (including tricyclic, SNR I antidepressants, or an AED), and there is no indication in the medical record that the claimant has failed a trial of these medications. Therefore, this request is not medically necessary.