

Case Number:	CM15-0019860		
Date Assigned:	02/09/2015	Date of Injury:	01/29/2013
Decision Date:	03/27/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	02/02/2015

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: Florida, New York, Pennsylvania
 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 injured worker (IW) is a 33 year old female who sustained an industrial injury on 01/29/2013. She has reported left shoulder pain and now also has pain in the right shoulder to right fingers. Diagnoses include reflex sympathetic dystrophy of the upper limb, pain in joint, forearm, cervical spondylosis with myelopathy, calcifying tendinitis of the shoulder. Treatment to date include medical management with shoulder girdle block, physical therapy and medications. A progress note from the treating provider dated 12/22/2014 indicates the IW has pain located in the entire left upper arm with tingling and numbness and weakness. The symptoms now have spread to the right upper arm all the way from the shoulder to right fingers. On examination the cervical spine has limited motion in flexion, extension, lateral rotation and lateral bending with increase in concordant pain in any planes. There is swelling of the left upper arm, discoloration in the upper chest, heat sensation to the left upper extremity with paleness in left hand. Motor strength is normal in the right upper extremity and diminished in the left. The left upper extremity is hypersensitive. Treatment plans included medications as previously prescribed, occupational therapy 6 sessions to continue with strengthening, desensitization and range of motion, and a home exercise program. On 12/31/2014 Utilization Review non-certified a request for Dilaudid 2mg 30 days noting the lack of documentation of analgesia, function, side effects and appropriate medication use. The MTUS, Guidelines were cited. On 12/31/2014 Utilization Review non-certified a request for Zofran 8mg #20 x30 days noting that Zofran is indicated for nausea and vomiting secondary to chemotherapy/radiation

treatment for postoperative use and for acute gastritis, not for the relief of nausea and vomiting secondary to chronic opioid use. The MTUS were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dilaudid 2mg 30 days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Part 2 Page(s): 13, 78.

Decision rationale: Assessment of treatment efficacy for opioids should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Actions for ongoing management should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Under these circumstances with the absence of adequate monitoring as recommended the UR Non-Cert of Dilaudid is supported.

Zofran 8mg #20 x30 days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.FDA.gov/drugs Zofran](http://www.FDA.gov/drugs)

Decision rationale: As stated in the UR documentation Zofran is indicated for nausea and vomiting secondary to chemotherapy/radiation treatment for postoperative use and for acute gastritis as per the FDA authorized indications. It is not for the relief of nausea and vomiting secondary to chronic opioid use. Additionally the member was already using both promethazine and hydroxyzine - both with antiemetic properties. Based on the lack of documentation of significant opiate related nausea and vomiting, absence of FDA approval for use for this indication and the presence of two other medications approved for general use in cases on nausea and vomiting the UR Non-Cert can be supported.

