

<b>Case Number:</b>	CM15-0022611		
<b>Date Assigned:</b>	03/17/2015	<b>Date of Injury:</b>	03/18/2007
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

### 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 48-year-old male, who sustained an industrial injury on 3/18/2007. Currently he reports right shoulder pain relieved with medication and resting. The injured worker was diagnosed with, and/or impressions were noted to include lumbar spine degenerative disc disease, right shoulder internal derangement and impingement - improving, and bilateral shoulder pain. Treatments to date have included consultations, with diagnostic laboratory and imaging studies; 2-D echo (10/9/14); right shoulder injection therapy; home exercise program; and medication management. The latest physician examination, dated 12/18/2014, notes the injured worker to be benefiting from taking his medications. The current treatment plan includes recommendations for continuation of his medications, a urinalysis study, and an intra-muscular Toradol injection, as the injured worker is unable to work.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE Norco 5/325mg Qty 60 (11/26/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute and Chronic), Low Back - Lumbar & Thoracic (Acute & Chronic), Shoulder, Pain, Opioids.

**Decision rationale:** ODG does not recommend the use of opioids for neck, low back, and shoulder pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage; this request alone exceeds that recommendation. MTUS does not discourage use of opioids past 2 weeks, but does state that "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." The treating physician does not adequately document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, the request for Norco 325/5mg is deemed not medically necessary.

**RETROSPECTIVE Ondansetron ODT 4mg Qty 30 (11/26/14): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter; Physician's Desk Reference.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants, NSAIDs, GI symptoms, opioids Page(s): 68-69, 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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-nor epinephrine 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. Available medical records indicate this IW is chronically using NSAIDs (anaprox). 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 HCL 4MG, #30 is not medically indicated.

