

Case Number:	CM13-0056075		
Date Assigned:	04/25/2014	Date of Injury:	06/13/2012
Decision Date:	06/11/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	11/21/2013

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 Emergency Medicine and is licensed to practice in California. 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 patient with reported a date of injury of 6/13/2012. There was no mechanism of injury provided. Patient has a diagnosis of osteoarthritis of lumbar spine, displacement of lumbar disc, degenerative lumbar disc and post laminectomy syndrome. There is a history of lumbar fusion in 1/15/13. Multiple medical reports from primary treating physician and consultants were reviewed. The last available report is dated 11/11/13. Patient complains of lower back pain. Pain is dull, burning and intermittent radiating to upper arms. Numbness reported in both legs along with weakness. Pain worsens with prolonged sitting. The patient reports pain with medications and physical therapy. She is able to perform her Activities of Daily Living (ADL). Pain is rated 3/10. Objective exam reveals normal gait with no significant pain. Some pain from heel with walking, paralumbar spasms and tenderness to palpation. Diffusely decreased range of motion (ROM) of lumbar spine. Straight leg positive bilaterally. Bilateral lower extremity reflexes are absent. Light touch is decreased on right leg and left feet. Motor strength is intact. Reports of X-rays, MRIs and EMG that were done in the past were not provided. Urine Drug screen from 7/24/13 reveals hydrocodone as prescribed. Patient is undergoing physical therapy. There was no medication list provided. Utilization review is for prescription for ondansetron 8mg, #30 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONDANSETRON 8 MG, QTY: 30 WITH 2 REFILLS: 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 Official Disability Guidelines (ODG) Pain (Chronic), Anti-Emetics (For Opioid Nausea).

Decision rationale: There are no relevant sections in the MTUS Chronic pain or ACOEM guidelines concerning this topic. Ondansetron is an anti-nausea medication. As per Official Disability Guidelines (ODG), anti emetics should only be used for short term nausea associated with opioids. Long term use is not recommended. There is no documentation provided by treating physicians about nausea or any complaints of nausea. Therefore, due to lack of documentation with no noted symptoms that warrant an anti-emetic, the request for Ondansetron 8mg #30 with 2 refills is not medically necessary and appropriate.