MAXIMUS Federal Services

Case Number:	CM14-0004286		
Date Assigned:	02/05/2014	Date of Injury:	07/23/2011
Decision Date:	07/14/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	01/10/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 52-year-old male with a reported injury on 07/23/2011. The mechanism of injury was not provided within the clinical documentation. The clinical note dated 07/11/2013 reported that the injured worker complained of neck and low back pain. The physical examination revealed cervical spine range of motion was restricted, demonstrating forward flexion to 45 degrees, extension to 45 degrees, right lateral tilt to 30 degrees, left lateral tilt to 30 degrees, right rotation to 60 degrees, and left rotation to 60 degrees. It was reported the injured worker's upper extremity sensation to light touch was diminished over the C5 and C6 dermatomes. The injured worker's diagnoses included degeneration of cervical intervertebral disc; cervical disc displacement; cervical radiculitis to low back; low back pain; lumbar disc displacement; and lumbar radiculopathy. The provider requested Ondansetron 8 mg tabs; the rationale was not provided within the clinical notes. The Request for Authorization was submitted on 01/09/2014. The injured worker's prior treatments were not provided within the clinical note.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONDANSETRON HCL 8 MG TAB, #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Ondansetron (Zofran).

Decision rationale: The request for Ondansetron HCL 8 mg tabs, quantity: 30 is not medically necessary. The injured worker complained of neck and low back pain. The treating physician did not indicate the rationale for Ondansetron in clinical documentation. The Official Disability Guidelines do not recommend Ondansetron (Zofran) for nausea and vomiting secondary to chronic opioid use. There is a lack of clinical information provided documenting the efficacy of Ondansetron as evidenced by decreased nausea and vomiting and significant objective functional improvements. The rationale for the Ondansetron request was not provided within the clinical documentation. Furthermore, the requesting provider did not specify the utilization frequency of the medication being requested. As such, the request is not medically necessary.