

Case Number:	CM14-0105903		
Date Assigned:	07/30/2014	Date of Injury:	12/09/2013
Decision Date:	08/29/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/09/2014

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 & Rehabilitation and is licensed to practice in Texas and Ohio. 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 53-year-old female who reported an injury on 12/09/2013. The mechanism of injury was not stated. Current diagnoses include musculoligamentous sprain of the lumbar spine with lower extremity radiculitis; compression fracture of L1 and L2; disc bulging in the lumbar spine; spondylolisthesis; transitional vertebrae at L5-S1; and cyst, synovial or nerve root at L5-S1. The injured worker was evaluated on 05/12/2014 with complaints of persistent pain, diminished sensation in the right lower extremity, and difficulty sleeping. Previous conservative treatment includes medication management and heat therapy. Physical examination only revealed tenderness over the posterior superior iliac spine. Treatment recommendations included a prescription for tramadol/acetaminophen/ondansetron 50/250/2 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol/APAP/Ondansetron 100/250/2mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic trial of opioids, opioids for chronic pain in general conditions. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Pain Procedure Summary last updated 10/14/2013: Ondansetron (Zofran).Mosby's Drug Consult - Zofran/Ondansetron,Official Disability Guidelines - TWC Pain Procedure Summary last updated 03/18/2014: Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Ondansetron, Antiemetic.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The Official Disability Guidelines state Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. It is recommended for nausea and vomiting secondary to chemotherapy and radiation treatment. Therefore, the current request cannot be determined as medically appropriate in this case. There is also no frequency listed in the current request. As such, the request is not medically necessary.