

<b>Case Number:</b>	CM14-0112167		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	01/16/2003
<b>Decision Date:</b>	10/17/2014	<b>UR Denial Date:</b>	06/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/18/2014

### 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 Anesthesiologist and Pain Medicine, and is licensed to practice in Florida. 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 49-year-old female who reported an injury on 01/16/2003. The mechanism of injury was not provided. The injured worker's diagnoses included irritable bowel syndrome, GERD, insomnia, cervical spine radiculopathy, strain and radiculopathy of the lumbar spine, and status post shoulder symptoms with residual weakness. The injured worker's past treatments included medications. On the clinical note dated 05/12/2014 (this note was handwritten and illegible), the injured worker complained of nausea with vomiting. The injured worker complained of pain at bedtime increased throughout back. The injured worker denies side effects of new medications. The injured worker had decreased range of motion to the cervical and lumbar spine. The injured worker had positive straight leg raise. The injured worker's medications included Neurontin 600 mg, trazodone 150 mg, Dexilant, Prozac 2 mg. The request was for retrospective Zofran 8 mg quantity 30, date of service 06/16/2011. The rationale for the request was for nausea and vomiting. The request for authorization was submitted on 06/16/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for Zofran 8mg, qty 30, DOS 06/16/2011:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain, Antiemetics.

**Decision rationale:** The request for Retrospective request for Zofran 8mg, qty 30, DOS 06/16/2011 is not medically necessary. The injured worker is diagnosed with irritable bowel syndrome, GERD, insomnia, cervical radiculopathy and strain, lumbar radiculopathy, status post right shoulder symptoms with residual weakness. The injured worker complained of nausea and vomiting as well as increased pain throughout the back. The Official Disability Guidelines do not recommend antiemetics for opioid nausea for nausea and vomiting secondary to chronic opioid use. They are however recommended for acute use as approved by the FDA. Nausea and vomiting is a common side effect with opioid use. There is lack of documentation indicating the injured worker had nausea and vomiting stemming back to 06/16/2011. The requesting physician does not provide documentation dating back for 2011. There is a lack of documentation indicating the injured worker had significant functional improvement with medication. Additionally, the request does not indicate the frequency of the medication. As such, the request for Retrospective request for Zofran 8mg, qty 30, DOS 06/16/2011 is not medically necessary.