

Case Number:	CM14-0096486		
Date Assigned:	08/13/2014	Date of Injury:	07/09/2003
Decision Date:	10/29/2014	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	06/24/2014

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, has a subspecialty in Pain Management 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 59 year old male who sustained an injury on 07/09/03 while moving materials to a cart. The injured worker developed complaints of low back pain radiating to the right lower extremity. The injured worker is noted to have undergone a prior right total knee arthroplasty as well as a lumbar posterior lumbar interbody fusion at L4-5 and L5-S1 on 10/31/12. The clinical report dated 06/07/14 noted that there were concerns regarding the presence of cellulitis in the left lower extremity following a revision procedure on 06/02/14. Medications did include oxycodone and Tramadol. The injured worker's medications were denied on 06/02/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zofran: 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 /Ondansetron (Zofran): Antiemetics (for opioid nausea)

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

Decision rationale: In review of the clinical documentation provided, the requested Zofran would not be supported as medically necessary per current evidence based guideline recommendations. Zofran is FDA indicated for the treatment of nausea and vomiting secondary to chemotherapy or radiation therapy as well as a post-operative medication. These indications are not present in the clinical record. Guidelines do not recommend the use of this medication to address nausea and vomiting as side effects of certain medications. The recommendation is to adjust the injured worker's medications to avoid these side effects. The clinical documentation is unclear regarding the use of Zofran and whether this was for the revision procedures performed on 06/02/14. This medication was not being actively prescribed by pain management. The request is also not specific in terms of dose, quantity, frequency, or duration. As such, this reviewer would not have recommended this medication as medically necessary.