

<b>Case Number:</b>	CM14-0160114		
<b>Date Assigned:</b>	10/03/2014	<b>Date of Injury:</b>	10/28/2009
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Emergency Medicine

### 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 (IW) is a 47 year old female who sustained an industrial injury on 10/28/2009. She has reported complaint of constant pain in the low back rated as an 8 on a scale of 10. The pain is aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, prolonged standing and walking multiple blocks. The pain is characterized as sharp and radiating into the lower extremities. Diagnoses include disc disorder, lumbar. Treatments to date include medications for pain and muscle spasm. Medications are also given for nausea associated with headaches that are present in the chronic cervical spine pain. A progress note from the treating provider dated 8/15/2014 indicates the lumbar spine has palpable paravertebral muscle tenderness with spasm. Range of motion is guarded and restricted. There is no evidence of stability on exam. The posterior leg and lateral foot have tingling and numbness in a S1 innervation. Ankle reflexes are asymmetric. The IW also complains of headaches from the neck pain. The plan of care includes continuation of medications as prescribed prior including Omeprazole 20 mg, Ondansetron 8 mg ODT, Cyclobenzaprine Hydrochloride tablets 7.5 mg, and Tramadol ER 150..On 09/16/2014 Utilization Review non-certified a request for Ondansetron 8mg #30. The ODG were cited. Utilization Review also non-certified a request for Tramadol ER 150mg #90. The MTUS Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ondansetron 8mg #30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC), Pain Procedure Summary, updated 08/04/2014.

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

**Decision rationale:** The requested Ondansetron 8mg #30, is not medically necessary. CA MTUS 2009 ACOEM is silent on this issue. ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Pain (Chronic), Ondansetron (Zofran), note Not recommended for nausea and vomiting secondary to chronic opioid use. The treating physician has documented lumbar spine has palpable paravertebral muscle tenderness with spasm. Range of motion is guarded and restricted. There is no evidence of stability on exam. The posterior leg and lateral foot have tingling and numbness in a S1 innervation. Ankle reflexes are asymmetric. The treating physician has not documented symptoms of nausea and vomiting, duration of treatment, nor derived functional improvement from its use. The criteria noted above not having been met, Ondansetron 8mg #30 is not medically necessary.

**Tramadol ER 150mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, and Tramadol, Page 113 Page(s): 78-82, 113.

**Decision rationale:** The requested Tramadol ER 150mg #90, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, and Tramadol, Page 113, do not recommend this synthetic opioid as first- line therapy, and recommend continued use of opiates for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The treating physician has documented lumbar spine has palpable paravertebral muscle tenderness with spasm. Range of motion is guarded and restricted. There is no evidence of stability on exam. The posterior leg and lateral foot have tingling and numbness in a S1 innervation. Ankle reflexes are asymmetric. The treating physician has not documented failed first-line opiate trials, VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract nor urine drug screening. The criteria noted above not having been met, Tramadol ER 150mg #90 is not medically necessary.

