

<b>Case Number:</b>	CM14-0209129		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	06/13/2012
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	11/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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: Physical Medicine & Rehabilitation

### 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 58 year old female, who sustained an industrial injury on June 13, 2012. She has reported lower back pain with numbness in the bilateral lower extremities. The diagnoses have included status post posterior lumbar fusion at lumbar 4-sacral 1 in 2013 and retained symptomatic lumbar spine hardware. On November 21, 2014, the injured worker underwent removal of hardware lumbar 4-sacral 1. Treatment to date has included x-rays, electrodiagnostic studies, work modifications, physical therapy, epidural steroid injections, topical and oral pain medication, and muscle relaxant medication. On November 22, 2014, the treating physician noted complaints of pain and mild nausea. The physical exam revealed a soft abdomen without tenderness, rigidity, or organomegaly. On December 15, 2014, the injured worker submitted an application for IMR for review of a prescription for Levofloxacin 750mg once a day for 7 days Qty: 30 and a prescription for Ondansetron 8mg ODT maximum 2 per day #30. The Levofloxacin was non-certified based on insufficient clinical information to support the medication request. The Ondansetron was non-certified based on lack of evidence of any gastrointestinal distress or gastritis to support the continued use of this medication. The California Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Levofloxacin 750mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines chapter 'Infectious diseases' and topic 'Levofloxacin (Levaquin®)

**Decision rationale:** Based on the 11/19/14 progress report provided by treating physician, the patient presents with low back pain rated 7/10 and weakness and numbness in the left leg. The request is for LEVOFLOXACIN 750MG #30. Patient's diagnosis on 11/22/14 included prior L4-S1 posterior lumbar interbody fusion with painful hardware; hypothyroidism; and status post removal of the hardware with inspection of the fusion mass. Patient's medications include Flexeril and Tramadol, per treater report dated 05/20/14. The patient is to remain off-work, per treater report dated 11/19/14. ODG guidelines, chapter 'Infectious diseases' and topic 'Levofloxacin (Levaquin)', states that the medication is Recommended as first-line treatment for osteomyelitis, chronic bronchitis, and pneumonia (CAP). In this case, none of the progress reports discuss the need for Levofloxacin. The RFA for this request has not been provided. The available medical reports do not provide the information required to make a determination based on ODG guidelines and there is no documentation of osteomyelitis, chronic bronchitis or pneumonia. There is no evidence of any hardware infection concerns either. Therefore, the request IS NOT medically necessary.

**Ondansetron 8mg ODT #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain (Chronic) chapter, Antiemetics (for opioid nausea

**Decision rationale:** Based on the 11/19/14 progress report provided by treating physician, the patient presents with low back pain rated 7/10 and weakness and numbness in the left leg. The request is for ONDANSETRON 8MG ODT #30. Patient's diagnosis on 11/22/14 included prior L4-S1 posterior lumbar interbody fusion with painful hardware; hypothyroidism; and status post removal of the hardware with inspection of the fusion mass. The patient is to remain off-work, per treater report dated 11/19/14. ODG guidelines have the following regarding antiemetics: "ODG Guidelines, Pain (Chronic) chapter, Antiemetics (for opioid nausea): Not recommended for nausea and vomiting secondary to chronic opioid use."Treater has not provided reason for the request. None of the progress reports discuss the need for Ondansetron or complaints of nausea. It appears treater is requesting this medication for nausea, since patient's medications include Flexeril and Tramadol, per treater report dated 05/20/14. However, guidelines do not support

this medication for nausea secondary to chronic opioid use. Therefore, the request IS NOT medically necessary.