

Case Number:	CM15-0009248		
Date Assigned:	01/27/2015	Date of Injury:	01/01/2008
Decision Date:	04/08/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/15/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 64 year old female patient who sustained an industrial injury on 01/01/2008 due to repetitive activities. Per the progress note from the treating provider dated 10/10/2012, she had complaints of neck pain, right shoulder pain, right upper extremity pain and low back pain. Review of systems revealed she had no nausea or vomiting. The physical examination revealed tenderness and decreased range of motion of the cervical spine, lumbar spine and right shoulder. Medications included Zofran, Tramadol, Flexeril and Naprosyn. A QME exam 10/05/2011 listed her diagnoses as depressive disorder not otherwise specified. Most recent treatment to date as described in the utilization review of 12/31/2014 includes a left cubital tunnel release procedure performed 07/24/2013. She has had multiple diagnostic studies including a MRI of the cervical spine, lumbar spine, a MR arthrogram of the right shoulder, EMG/NCV (electromyogram/nerve conduction velocity) of the upper and lower extremities. She has had lumbosacral brace, chiropractic care and physical therapy. On 12/31/2014 Utilization Review non-certified a Retrospective Ondansetron DOS (10/10/2012). The Official Disability Guidelines (ODG), Pain Chapter, Ondansetron were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Ondansetron DOS (10/10/2012): 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), Pain Chapter, Ondansetron.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Pain (updated 03/23/15) Ondansetron (Zofran; 1/2) Antiemetics (for opioid nausea).

Decision rationale: Request: Retrospective Ondansetron DOS (10/10/2012) Ondansetron is 5-HT₃ receptor antagonist which acts as anti-emetic drug. CA MTUS/ACOEM do not address this request. Therefore ODG was used. According to the ODG guidelines, "Ondansetron (Zofran): This drug is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis." Evidence of nausea or vomiting was not specified in the records provided. Any evidence of chemotherapy and radiation treatment was not specified in the records provided. Evidence of surgery at the time of prescription was not specified in the records provided. A detailed gastrointestinal examination was not specified in the records provided. The medical necessity of retrospective Ondansetron DOS (10/10/2012) was not established for this patient.