

<b>Case Number:</b>	CM15-0109095		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	11/14/2001
<b>Decision Date:</b>	07/17/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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 65 year old female patient, who sustained an industrial injury on 11/14/2001. The mechanism of injury was a slip and fall. The diagnoses include carpal tunnel syndrome and lumbosacral neuritis. Per the doctor's note dated 6/15/2015, she had complaints of intermittent low back pain, hardware related pain and right wrist/hand pain. The physical examination revealed lumbar spine; tenderness, spasm and decreased range of motion; right wrist/hand; well healed surgical incision. Per the progress note dated 1/12/2015, she had complains of intermittent low back pain, rated 3/10, aggravated by bending and twisting and right hand/wrist pain, rated 3/10. Physical examination showed lumbar paravertebral muscle tenderness and right wrist stiffness. The medications list includes tramadol, fenoprofen, cyclobenzaprine, omeprazole and ondansetron. She has undergone lumbar L4-S1 interbody fusion, right carpal tunnel release, multiple ankle/foot surgeries and knee arthroplasty. Lumbar x rays showed good alignment. She has had physical therapy for this injury. The treating physician is requesting Tramadol 150 mg #90 and Ondansetron 8 mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol 150 mg #90:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page 75, Central acting analgesics Page 82, Opioids for neuropathic pain.

**Decision rationale:** Q-- Tramadol 150 mg #90. Tramadol is a centrally acting synthetic opioid analgesic. According to MTUS guidelines "Central acting analgesics: an emerging fourth class of opiate analgesic that may be used to treat chronic pain. This small class of synthetic opioids (e.g., Tramadol) exhibits opioid activity and a mechanism of action that inhibits the reuptake of serotonin and nor epinephrine. Central analgesics drugs such as Tramadol (Ultram) are reported to be effective in managing neuropathic pain. (Kumar, 2003)" Cited guidelines also state that, "A recent consensus guideline stated that opioids could be considered first-line therapy for the following circumstances: (1) prompt pain relief while titrating a first-line drug; (2) treatment of episodic exacerbations of severe pain; and (3) treatment of neuropathic cancer pain." Tramadol use is recommended for treatment of episodic exacerbations of severe pain. Per the records provided, she had chronic low back pain and right hand/wrist pain with history of lumbar and right wrist surgeries. She was noted to have significant objective evidence of abnormalities on physical exam- lumbar paravertebral muscle tenderness and right wrist stiffness. There was objective evidence of conditions that can cause chronic pain with episodic exacerbations. The request for Tramadol 150 mg #90 is medically appropriate and necessary to use as prn during acute exacerbations.

**Ondansetron 8 mg #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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chapter: Pain (updated 06/15/15) Ondansetron (Zofran) Antiemetics (for opioid nausea).

**Decision rationale:** Q--Ondansetron 8 mg #30. Ondansetron is 5-HT<sub>3</sub> 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-HT<sub>3</sub> 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." A detailed history related to nausea or vomiting is not specified in the records provided. Any evidence of chemotherapy and radiation treatment is not specified in the records provided. Evidence of recent surgery is not specified in the records provided. A recent detailed gastrointestinal examination is not specified in the records provided. The medical necessity of Ondansetron 8 mg #30 is not established for this patient.