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| Case Number: | CM15-0019414 | | |
| Date Assigned: | 02/09/2015 | Date of Injury: | 09/12/2012 |
| Decision Date: | 05/12/2015 | UR Denial Date: | 01/08/2015 |
| Priority: | Standard | Application Received: | 02/03/2015 |

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

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 32 year old female with an industrial injury dated September 12, 2012. The injured worker diagnoses include complex regional pain syndrome, left upper extremity consistent with swelling, discoloration, hypersensitivity, allodynia, aggravated following disability examination of 7/21/2014, severe left cervical sprain, severe left shoulder adhesive capsulitis (frozen shoulder), and left lateral epicondylitis. She has been treated with diagnostic studies, prescribed medications and periodic follow up visits. According to the progress note dated 12/18/2014, the injured worker reported severe pain in the left neck, left upper extremity, left upper back radiating to the hand associated with progressive numbness of the left hand and forearm. The treating plan included medication management. The treating physician prescribed Zofran 8mg # 60 for nausea now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zofran 8mg # 60: 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 Index, 12th Edition (web), 2014, Pain Chapter, Ondansetron (Zonfran).

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

Decision rationale: Accordingly to the ODG, Zofran 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. According to the documents available for review, the injured worker does not have any of the FDA approved indications for the use of this medication. Therefore at this time the requirements for treatment have not been met and medical necessity has not been established.