

<b>Case Number:</b>	CM15-0062284		
<b>Date Assigned:</b>	04/08/2015	<b>Date of Injury:</b>	09/19/2011
<b>Decision Date:</b>	05/07/2015	<b>UR Denial Date:</b>	03/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2015

### 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: New York

Certification(s)/Specialty: Internal 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 is a 50 year old female who sustained an industrial injury on 09/19/2011. Diagnoses include sprain hip and thigh bilateral, contusion of the right foot resolved, trochanteric bursitis on the right, labrum tear hip, aftercare for healing traumatic right hip fracture, and sprain of hip and thigh on the right. Treatment to date has included diagnostic studies, medications, physical therapy, cortisone injections, and right hip arthrography on 02/06/2015. A physician progress note dated 03/10/2015 documents the injured worker has chronic right hip pain. The pain and symptoms are mild and is described as discomforting. Pain is located in the anterior region on the right side. There is pain with flexion and internal rotation of the hip. She has pain with ambulation, and gait is normal. The injured worker will proceed with surgical treatment consisting of hip arthroscopy with labral repair versus debridement and decompression of FAI. Treatment plan is for medications and follow up with care 1 week post-surgery. Treatment requested is for Zofran 4mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zofran 4mg #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), Pain.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Antiemetics.

**Decision rationale:** Ondansetron, originally marketed under the brand name Zofran, is a serotonin 5-HT<sub>3</sub> receptor antagonist used to prevent nausea and vomiting caused by cancer chemotherapy, radiation therapy and surgery. There is no specific indication for the requested medication. The claimant is to proceed with surgery but there is no indication that Zofran would be necessary without evidence of post-operative nausea and vomiting. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.