

<b>Case Number:</b>	CM15-0063986		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	09/12/2011
<b>Decision Date:</b>	07/27/2015	<b>UR Denial Date:</b>	03/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2015

### 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: Arizona, 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:

The injured worker is a 56 year old female, who sustained an industrial injury on 9/12/11. She has reported initial complaints of right arm, hand and wrist injury from repetitive use. The diagnoses have included status post anterior cervical discectomy and fusion, status post right carpal cubital tunnel release and carpal cubital syndrome/double crush syndrome. Treatment to date has included medications, activity modifications, off work, diagnostics, bracing, surgery, physical therapy and other modalities. Currently, as per the physician progress note dated 3/2/15, the injured worker complains of intermittent pain in the cervical spine with stiffness and persistent pain in the bilateral upper extremities that is aggravated by repetitious motions. The pain remains unchanged. The physical exam of the cervical spine reveals that the range of motion is full with pain. The upper extremity exam reveals tenderness over the volar aspect of the left wrist, positive palmar compression test with subsequent Phalen's maneuver. There is positive Tinel's sign over the carpal canal and positive Tinel's sign at the left elbow. There is also pain with terminal flexion. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the cervical spine and x-rays of the cervical spine. The current medications were not listed and there is no previous physical therapy sessions noted in the records. The physician requested treatments included One prescription of Ondansetron 8mg #30 (through [REDACTED]), One prescription of Tramadol ER 150mg #90 (through [REDACTED]), and Levofloxacin 750mg #30 (through [REDACTED]).

## IMR ISSUES, DECISIONS AND RATIONALES

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

**One prescription of Ondansetron 8mg #30 (through [REDACTED]):** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- pain chapter and anti-emetics and pg 14.

**Decision rationale:** According to the ODG guidelines, antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Zofran (Ondansetron) 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. In this case, the claimant does not have the above diagnoses. The claimant was on Ondansetron for over 2 years due to nausea from headaches and cervical pain. The request to continue Ondansetron is not supported by the guidelines and is not medically necessary.

**One prescription of Tramadol ER 150mg #90 (through [REDACTED]):**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 92-93.

**Decision rationale:** Tramadol is a synthetic opioid affecting the central nervous system. According to the MTUS guidelines, Tramadol is recommended on a trial basis for short-term use after there has been evidence of failure of first-line non-pharmacologic, medication options (such as acetaminophen or NSAIDs), and when there is evidence of moderate to severe pain. In this case, the claimant was on Tramadol for over 2 years. Long-term use is not supported by the guidelines. Weaning attempt or Tylenol failure was not noted. The claimant was on the maximum dose. The continued use of Tramadol ER as above is not medically necessary.

**Levofloxacin 750mg #30 (through [REDACTED]):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation North American Spine Society.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- infectious chapter and pg 16.

**Decision rationale:** According to the guidelines, Levaquin is recommended as first-line treatment for osteomyelitis, chronic bronchitis, and pneumonia (CAP). In this case, the prior

surgical scar was healed. There were no signs of active infection. Indication for Levaquin was not justified. It is not the 1st choice for skin infection or pain. The request for Levaquin is not medically necessary.