

<b>Case Number:</b>	CM14-0186981		
<b>Date Assigned:</b>	11/17/2014	<b>Date of Injury:</b>	01/20/2011
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	10/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 54 year old male with a date of injury of 1/20/14. The listed diagnoses are lumbar radiculopathy, post laminectomy cervical, lumbar spondylosis and pain in joint involving shoulder region. The patient is status post ACDF C5-7 on 9/18/2012 and right shoulder reconstruction surgery on 6/30/13. According to progress report 10/3/14, the patient presents with abdominal, back, shoulder and neck pain. The back pain radiates into the right groin and down the right leg to the foot. The shoulder pain is constant and worsened by use of the extremity and relieved with medication. The patient is utilizing Hydromorphone 2mg which provides him 20-40% relief. He also continues with Oxycontin along with Hydromorphone for breakthrough pain relief. He is also utilizing Nexium BID for relief of dyspepsia and Zofran for intermittent nausea. The recommendation is for refill of medications. Utilization review denied the request on 10/10/14. Treatment reports from 3/6/14 through 10/29/14 were provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zofran Tab 4mg #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),

Ondansetron (Zofran) and on the Non-MTUS US National Library of Medicine, Ondansetron, <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000157/>

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) chapter, Antiemetics (for opioid nausea)

**Decision rationale:** This patient presents with abdominal, back, shoulder and neck pain. The current request is for ZOFRAN TAB 4MG #60. ODG guidelines have the following regarding antiemetics: "ODG Guidelines, Pain (Chronic) chapter, Antiemetics (for opioid nausea): Not recommended for nausea and vomiting secondary to chronic opioid use. 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." The treater indicates that the patient is utilizing Zofran for "intermittent nausea." The treater has not indicated that patient is postoperative, undergoing chemotherapy and radiation, or has gastroenteritis, as recommended by ODG and the FDA. Furthermore, Ondansetron is not recommended by ODG for nausea and vomiting secondary to chronic opioid use. The request does not meet guideline indications. Recommendation is for denial.