

Case Number:	CM15-0161080		
Date Assigned:	09/23/2015	Date of Injury:	08/28/2011
Decision Date:	11/03/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/17/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 43 year old male, who sustained an industrial injury on 08-28-2011. He has reported injury to the low back. The injured worker has been treated for lower back pain; lumbar disc displacement; and lumbar discopathy. Treatment to date has included medications, diagnostics, injections, and physical therapy. Medications have included Ibuprofen, Tramadol, Relafen, Cyclobenzaprine, Ondansetron, and Lansoprazole. A progress report from the treating physician, dated 06-16-2015, documented a follow-up visit with the injured worker. The injured worker reported there is intermittent pain in the low back; the pain is characterized as dull and there is radiation of pain into the lower extremities; the pain is rated at 4 out of 10 in intensity; the pain is aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, and prolonged standing; he is taking his medications as directed; and he is benefitting from taking these medications. Objective findings included he is in no acute distress; there is palpable lumbar paravertebral muscle tenderness with spasm; seated nerve root test is positive; standing flexion and extension are guarded and restricted; and sensation and strength are normal. The treatment plan has included the request for 30 Ondansetron 8mg. The original utilization review, dated 08-05-2015, non-certified a request for 30 Ondansetron 8mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 Ondansetron 8mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA approved. Antiemetics (for opioid nausea).

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, under Antiemetics (for opioid nausea).

Decision rationale: The patient presents with low back pain, rated 4/10. The request is for 30 ONDASETRON 8MG. Physical examination to the lumbar spine on 06/16/15 revealed tenderness to palpation to the paravertebral muscles with spasm. Range of motion was noted to be restricted. Per Request for Authorization form dated 07/21/15, patient's diagnosis includes lumbago. Patient's medications, per Request for Authorization form dated 07/21/15 include Nabumatone, Lansoprazole, Ondansetron, Cyclobenzaprine, and Tramadol. Patient's work status is modified duties. 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-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." The treater has not specifically discussed this request. A prescription for Ondansetron was first noted in prescriptive note dated 07/13/15. It appears that the treater is initiating this medication, as there are no prior records of the patient utilizing Ondansetron. In this case; the treater has not indicated that patient is postoperative, undergoing chemotherapy and radiation. ODG and FDA recommend this medication for acute gastroenteritis which this patient does not have. The request does not meet guideline indications. Therefore, the request IS NOT medically necessary.