

<b>Case Number:</b>	CM15-0067546		
<b>Date Assigned:</b>	04/15/2015	<b>Date of Injury:</b>	11/05/2003
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	03/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/09/2015

### 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: Emergency 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 53-year-old male, who sustained an industrial injury on 11/5/2003. The current diagnoses are post-lumbar laminectomy syndrome, status post L5-S2 fusion, medication- induced gastritis, and reactionary depression/anxiety with associated sleep disturbance. According to the progress report dated 3/2/2015, the injured worker complains of persistent neck and low back pain, but much more manageable with the use of intrathecal Morphine pump. The pain is rated 7/10 on a subjective pain scale. The current medications are Norco, Prilosec, Anaprox, Zofran, and Neurontin. Additionally, he reports chronic nausea. Without Zofran, he complains of significant nausea and vomiting. Treatment to date has included medication management, MRI studies, electro diagnostic testing, home exercise program, intrathecal Morphine pump, and surgical intervention. The plan of care includes aqua therapy, orthopedic mattress, Zofran, Prilosec, Anaprox, and Norco.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AQUA THERAPY 2 X 6 WEEKS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy, Page 22 Page(s): 22.

**Decision rationale:** The requested AQUA THERAPY 2 X 6 WEEKS is not medically necessary. Chronic Pain Medical Treatment Guidelines, Aquatic Therapy, Page 22, note that aquatic therapy is "Recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity." The injured worker has persistent neck and low back pain, but much more manageable with the use of intrathecal Morphine pump. The treating physician has not documented failed land-based therapy nor the patient's inability to tolerate a gravity-resisted therapy program. The treating physician has not documented objective evidence of derived functional benefit from completed aquatic therapy sessions, such as improvements in activities of daily living, reduced work restrictions, or decreased reliance on medical intervention. The criteria noted above not having been met, AQUA THERAPY 2 X 6 WEEKS is not medically necessary.

**ORTHOPEDIC MATTRESS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

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

**Decision rationale:** The requested ORTHOPEDIC MATTRESS is not medically necessary. CA MTUS is silent. Official Disability Guidelines, Low Back, Mattress selection is not recommended to use firmness as sole criteria. The injured worker has persistent neck and low back pain, but much more manageable with the use of intrathecal Morphine pump. The treating physician has not documented failed land-based therapy nor the patient's inability to tolerate a gravity-resisted therapy program. The treating physician has not documented sufficient medical necessity for this DME as an outlier to referenced negative guideline recommendations. The criteria noted above not having been met, ORTHOPEDIC MATTRESS is not medically necessary.

**ZOFRAN ODT (ONDANSETRON) 8MG #10:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Ondansetron (Zofran®).

**Decision rationale:** The requested ZOFRAN ODT (ONDANSETRON) 8MG #10 is medically necessary. CA MTUS 2009 ACOEM is silent on this issue. Official Disability Guidelines, Pain

(Chronic), Ondansetron (Zofran), note, "Not recommended for nausea and vomiting secondary to chronic opioid use." The injured worker has persistent neck and low back pain, but much more manageable with the use of intrathecal Morphine pump. The treating physician has documented chronic nausea. Without Zofran, he complains of significant nausea and vomiting. The criteria for this medication's continued use have been established as an outlier to referenced guideline recommendations. The request for ZOFRAN ODT (ONDANSETRON) 8MG #10 is medically necessary.