
Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/12/2013
Date of Injury: 3/6/2009
IMR Application Received: 8/12/2013
MAXIMUS Case Number: CM13-0013294

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology, has a subspecialty in Cardiovascular Disease and is licensed to practice in Texas. 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 59-year-old female who reported an injury on 03/06/2009. The mechanism of injury was a fall. The patient developed bladder incontinence and underwent an endoscopy study that revealed a moderate sized hiatal hernia and mild reflux esophagitis and gastritis. Physical findings included a positive straight leg raising test bilaterally to 90 degrees, and limited range of motion of the lumbar spine to 40 degrees in flexion and 10 degrees in extension. The patient was diagnosed with moderate sized hiatal hernia with esophagitis and gastritis, vaginal prolapse, and status post lumbar spine surgery. The patient's treatment plan included Protonix 20 mg twice a day and Zofran 8 mg for nausea.

IMR DECISION(S) AND RATIONALE(S)

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

1. The retrospective request for Zofran ODT 8mg, #10 (DOS 07/15/2013) is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, May 2009, which is part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Official Disability Guidelines (ODG), Antiemetics (for opioid nausea).

The Physician Reviewer's decision rationale:

The employee does have a history of nausea. Additionally, the patient's diagnoses included mild reflux esophagitis and gastritis. California Medical Treatment Utilization Schedule does not

address this request. The Official Disability Guidelines state that Zofran is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatments and postoperative use. It is also stated that acute use is FDA approved for gastroenteritis. However, the evaluation for the date of service 07/15/2013 did not include evaluation of the patient for nausea related to her gastritis. The employee is taking Protonix to address symptoms related to the employee's reflux esophagitis and gastritis. It is unclear why additional medication is necessary. **The retrospective request for Zofran ODT, 8mg, #10 (DOS 07/15/13) is not medically necessary or appropriate.**

/sb

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.



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