

Case Number:	CM13-0053333		
Date Assigned:	12/30/2013	Date of Injury:	11/30/2011
Decision Date:	03/20/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	10/22/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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. 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 55-year-old male who reported an injury on 11/30/2011 due to a slip and fall. The patient reportedly sustained injury to multiple body parts including the bilateral wrists and elbows. The patient ultimately developed bilateral lateral epicondylitis and failed to respond to physical therapy, injection therapy, non-steroidal anti-inflammatory drugs, and bracing. The patient's most recent clinical findings included tenderness along the right wrist with complaints of pain rated at 8/10 without medications; reduced to 4/10 with the use of medications. The patient's treatment plan included right wrist arthroscopy and debridement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Polar Care x 21: 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 Official Disability Guidelines (ODG)

Decision rationale: The requested polar care unit x21 days is not medically necessary or appropriate. Official Disability Guidelines recommend the use of continuous cryotherapy in the postsurgical management of a patient's pain. However, Official Disability Guidelines only

recommend the use of this equipment for up to 7 days post surgically. The requested 21 days exceeds this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested polar care unit x 21 days is not medically necessary.

Zofran 8 mg #20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16 and 60.

Decision rationale: The requested Zofran 8 mg #20 is not medically necessary or appropriate. Official Disability Guidelines do recommend the use of this medication in the management of a patient's postsurgical nausea and vomiting. However, the clinical documentation does not provide an evaluation post surgically that indicates the patient has complaints of nausea and vomiting that require medication management. As such, the requested Zofran 8 mg #20 is not medically necessary or appropriate.

Neurontin 600 mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16 and 60.

Decision rationale: The requested Neurontin 600 mg #180 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate the patient has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule does recommend the use of anticonvulsants in the management of a patient's chronic pain. However, California Medical Treatment Utilization Schedule does state that continued use of medications in the management of chronic pain must be supported by a quantitative assessment to establish pain relief and documentation of increased functional benefit. The clinical documentation submitted for review does not provide any evidence of increased functional benefit as result of this medication. The clinical documentation does indicate the patient does have a reduction in pain; however, this reduction is directly attributed to the use of Norco. Therefore, continued use of this medication would not be indicated. As such, the requested Neurontin 600 mg #180 is not medically necessary or appropriate.

Rejuveness x1: 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: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, and Hand Chapter, Wound Dressing.

Decision rationale: The requested ReJuveness x1 is not medically necessary or appropriate. Official Disability Guidelines recommend this type of wound dressing for chronic wounds in patients who have evidence of fragile skin. The clinical documentation submitted for review does not provide any evidence the patient has fragile skin. As this type of wound dressing is not indicated for postsurgical wounds, the use of this wound dressing is not indicated. As such, the requested ReJuveness x1 is not medically necessary or appropriate.