

Case Number:	CM14-0013258		
Date Assigned:	02/26/2014	Date of Injury:	12/06/2001
Decision Date:	08/11/2014	UR Denial Date:	01/20/2014
Priority:	Standard	Application Received:	02/03/2014

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, 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 60-year-old male who has filed a claim for elbow pain associated with an industrial injury date of December 06, 2001. Review of progress notes indicates that the patient is tapering oxycontin. There is worsening left elbow pain, bilateral wrist pain, and right hand pain. The patient also suffers from depressive disorder and panic disorder with history of suicidal thoughts. Patient reports poor sleep quality, poor energy, anxiety, and mild fatigue. Findings include swelling and decreased range of motion of the left elbow, tenderness over the lateral and medial epicondyles, and hyperparesthesia to touch of the medial epicondyle. Examination of the right hand showed swelling over the thenar eminence, painful and limited range of motion of the first MCP joint, decreased temperature over the hand, and tenderness over the thenar eminence. There was dysesthesia over the bilateral hands and forearms. Treatment to date has included opioids, antidepressants, sedatives, psychotherapy, acupuncture, bilateral wrist bracing, bilateral elbow release, right thumb surgery, and trigger finger surgeries. Utilization review from January 16, 2014 denied the requests for paraffin wax device as there is no documentation of hand arthritis; in-home assistance for 2 hours twice weekly for 12 weeks to assist with basic household chores as there is no documentation that the patient requires medical treatment, or that the patient is homebound; clonazepam 0.5mg #30 as there is no documentation of the intended duration for use; and Zofran ODT 8mg #60 as there is no documentation regarding nausea and vomiting caused by radiation therapy, chemotherapy, or surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

PARAFIN WAX DEVICE.: 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) Forearm, Wrist, and Hand Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand chapter, Paraffin wax baths.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, paraffin wax baths are recommended as an option for arthritis baths if used as an adjunct to a program of evidence-based conservative care (exercise). However, there is no documentation regarding arthritis of the hands. Therefore, the request for paraffin wax device was not medically necessary.

CLONAZEPAM 0.5MG #30.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: As noted on page 24 of the CA MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Patient has been on this medication since November 2013. The patient is using this medication to decrease withdrawal symptoms during taper of oxycontin. However, this medication is only limited for a short course therapy. Therefore, the request for clonazepam 0.5mg #30 was not medically necessary.

IN-HOME ASSISTANCE FOR 2 HOURS TWICE WEEKLY FOR TWELVE WEEKS TO ASSIST WITH BASIC HOUSEHOLD CHORES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: As noted on page 51 of the CA Chronic Pain Medical Treatment Guidelines, home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week, which does not include homemaker services. There is no documentation regarding the need for services to render recommended medical treatment as this patient is not homebound. There is no support for this home health services to perform household chores. Therefore, the request for in-home assistance for 2 hours twice weekly for 12 weeks to assist with basic household chores was not medically necessary.

ZOFRAN ODT 8MG #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), Pain chapter, 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 chapter, Antiemetics (for opioid nausea).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, ondansetron is recommended for nausea and vomiting secondary to chemotherapy, radiation, and post operative use. Acute use is FDA-approved for gastroenteritis. It is not recommended for nausea and vomiting secondary to chronic opioid use. Patient has been on this medication since October 2013. There is no documentation of nausea of vomiting associated with chemotherapy, radiation therapy, and surgery. Therefore, the request for Zofran ODT 8mg #60 was not medically necessary.