MAXIMUS Federal Services

Case Number:	CM14-0162107		
Date Assigned:	10/27/2014	Date of Injury:	01/14/2006
Decision Date:	11/25/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	10/02/2014

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 Family Medicine and is licensed to practice in Arizona. 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:

Injured worker is a 48 year old female with a date of injury on 1/14/2006. Diagnoses include entrapment of hand flexor tendons, and right carpal tunnel syndrome. Prior surgery has included carpal tunnel release in 2007, followed by two more carpal tunnel releases, and right trigger thumb release in 2013. Subjective complaints are of aching, numbness and persistent tingling in the right hand. Physical exam showed aberrant tendon motion and paresthesias in the median nerve distribution. Provider had requested carpal tunnel neuroplasty, flexor tenosynovectomy, and tenolysis. These surgeries were approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold Therapy Unit x 30 days: 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) Cervical, Shoulder, Lumbar and Knee Chapters

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous Cryotherapy

Decision rationale: While CA MTUS does mention using thermal modalities as an initial therapy for acute pain or to aid in an exercise program, it does not specifically address a Therma Cooling system. ODG states that a "continuous-flow cryotherapy can be recommended as an option after surgery, but not for nonsurgical treatment." Postoperative use is generally up to 7 days. The request as written is for use of a cold therapy unit for 30 days. This amount of time exceeds guideline recommendations, and the medical necessity is not established. The request for Cold Therapy Unit x 30 days is not medically necessary.

Norco 10-325mg 1 every 4-6 hours PRN pain #90, 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82-88, 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The injured worker in question has been on chronic opioid therapy. CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. While ongoing opioids may be needed for this injured worker, the medical record fails to provide documentation of MTUS opioid compliance guidelines including risk assessment, attempts at weaning, and ongoing efficacy of medication. Furthermore, the records do not demonstrate improvement in function from long-term use. The medical necessity of Norco is not established; therefore, the request is not medically necessary.

Zofran 4mg 1 QD #30, 1 refill: Overturned

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 FDA: Ondansetron www.drugs.com.

Decision rationale: Ondansetron has FDA approval for short term use for nausea after anesthesia or chemotherapy, and for acute symptoms of gastroenteritis. Ondansetron, as per ODG guidelines is also not recommended for nausea secondary to opioid therapy. For this injured worker there has been approval for surgery, and the ondansetron appears to be requested for post-operative use. Medical necessity for ondansetron is established; therefore, the request for Zofran is medically necessary.