

Case Number:	CM14-0022103		
Date Assigned:	05/09/2014	Date of Injury:	05/02/2013
Decision Date:	07/10/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/21/2014

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 General Surgery 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 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 injured worker is a 32-year-old male who sustained an injury on 05/02/13. No specific mechanism of injury was noted. This was an overuse injury, which caused pain in the right shoulder and elbow with associated pain and swelling. The patient reported a gradual onset of left wrist pain. The patient was pending further surgical intervention for the right ulnar nerve including exploration and transposition. Previous electrodiagnostic studies noted evidence of cubital tunnel syndrome. The clinical record from 12/09/13 noted persistent tenderness to palpation over the right elbow and medial epicondyle and lateral epicondyle. There were positive Phalen's signs in the right upper extremity. The recommendations were for cubital tunnel release. The patient was recommended to continue with the right elbow splint and home exercises. Follow-up on 01/20/14 continued to note tenderness in the medial epicondyle of the right elbow, with positive Tinel signs. The patient continued to be recommended for right ulnar nerve transposition, which was performed on 01/29/14. A post-operative follow-up on 02/21/14 noted minimal evidence of swelling in the right upper extremity at the elbow. At the left wrist, there was a noted volar ganglion cyst with tenderness to palpation over the dorsal distal radius. There was some loss of range of motion in the left wrist. The requested Norco 10/325mg #120 was denied by utilization review on 02/03/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO (HYDROCODONE/APAP) 10/325 MG QUANTITY 120.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 88-89.

Decision rationale: In regards to the request for Norco 10/325mg #120, the clinical documentation submitted for review would not support this request as medically necessary. From the records provided for review, there was no clear indication for the ongoing use of Norco. It is unclear what if any substantial functional improvement or pain reduction was achieved with this medication. The patient was continually recommended for surgical intervention for the right upper extremity. The Chronic Pain Guidelines indicate that short acting narcotics, such as Norco can be considered in the treatment of moderate to severe musculoskeletal pain; however, there should be ongoing documentation regarding functional benefits and pain reduction attributed to ongoing use of short acting narcotic. As this was not clearly identified in the clinical records and as there was no documentation regarding compliance testing, such as toxicology results or long term opioid risk assessments.

ZOFRAN ODT (ONDANSETRON ODT) 8 MG QUANTITY 10:00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [HTTP://US.GSK.COM/PRODUCTS/ASSETS/US_ZOFRAN_TABLETS.PDF](http://us.gsk.com/products/assets/us_zofran_tablets.pdf)).

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, proton pump inhibitors.

Decision rationale: In regards to the use of Zofran 8mg #10, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. In regards to Zofran this medication is being utilized off label for this patient. The patient is not currently receiving any chemotherapy or radiative therapy, which is producing side effects such as nausea and vomiting. No recent surgical procedures have been completed for this patient. These are the only indications per FDA for the use of Zofran.