

<b>Case Number:</b>	CM13-0046104		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	07/12/2013
<b>Decision Date:</b>	03/07/2014	<b>UR Denial Date:</b>	10/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2013

### 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, has a subspecialty in Pain Medicine, and is licensed to practice in Oklahoma and 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. 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 49-year-old who reported an injury on 07/12/2013 due to repetitive trauma that reportedly caused injury to her right upper extremity and upper back. Previous treatment included medications, physical therapy and acupuncture. The patient's most recent clinical documentation indicated that the patient had 7 out of 10 pain, tenderness noted in the medial epicondyle on the right side with normal range of motion. It was also noted that the patient was self-administering ThermaCare Cold Wrap therapy. Patient's diagnoses included a sprain/strain of the elbow and medial epicondylitis. The patient's treatment plan included continuation of medications, and continuation of ThermaCare Cold Wrap therapy and acupuncture.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketoprofen 20% in PLO gel, 120 gm,:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111.

**Decision rationale:** The California Medical Treatment Utilization Schedule does not support the use of ketoprofen as a topical agent as it is not FDA approved for this formulation. The California Medical Treatment Utilization Schedule states that any medication that contains 1 drug or drug class that is not supported by guideline recommendations is not recommended. Therefore, the use of ketoprofen as a topical agent is not indicated. The request for Ketoprofen 20% in PLO gel, 120 gm, is not medically necessary or appropriate.

**Cyclophene 5% in PLO gel, 120 gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111.

**Decision rationale:** The Physician Reviewer's decision rationale: . The California Medical Treatment Utilization Schedule does not support the use of Cyclophene as a topical agent as it is not FDA approved for this formulation. The California Medical Treatment Utilization Schedule states that any medication that contains 1 drug or drug class that is not supported by guideline recommendations is not recommended. Therefore, the use of Cyclophene as a topical agent is not indicated. The request for Cyclophene 5% in PLO gel, 120 gm, is not medically necessary or appropriate.

**Synapryn 10mg/1ml, 550ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Section, and Glucosamine (and Chondroitin Sulfate) Section. Page(s):.

**Decision rationale:** This is a compounded medication with glucosamine and tramadol. The California Medical Treatment Utilization Schedule recommends the use of glucosamine for patients who have osteoarthritic pain. The clinical documentation submitted for review does not provide any evidence that the patient's pain is related to osteoarthritis. The California Medical Treatment Utilization Schedule recommends the use of tramadol be supported by a quantitative assessment of pain relief, documentation of functional benefit, managed side effects, and monitoring for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is regularly monitored for aberrant behavior. However, the clinical documentation does not provide any evidence of functional benefit or a quantitative assessment of pain relief related to this medication. Additionally, the clinical documentation does not provide any evidence that the patient cannot tolerate a regular oral formulation and that a liquid formulation is required. Therefore, the continued use of this medication would not be indicated. The request for Synapryn 10mg/1ml, 550ml, is not medically necessary or appropriate.

**Tabradol 1mg/cc, 250 ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Section Page(s): 60.

**Decision rationale:** The requested medication contains Cyclobenzaprine. The California Medical Treatment Utilization Schedule recommends muscle relaxants for the management of pain and muscle spasming for short durations. The patient's most recent clinical exam findings did not include any evidence of muscle spasming that would benefit from a muscle relaxant. Also, the clinical documentation did not provide any evidence that the patient could not tolerate solid formulation of this medication. There was no support provided that the patient required an oral liquid formulation of this medication. Therefore, continued use would not be indicated. The request for Tabradol 1mg/cc, 250 ml, is not medically necessary or appropriate.

**Deprizine 150mg/ml, 250 ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI (gastrointestinal) Symptoms & Cardiovascular.

**Decision rationale:** The requested medication contains Ranitidine. The California Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectants when the patient is at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation does not provide an adequate assessment of the patient's gastro intestinal system to support that the patient is at risk for development of disturbances related to medication usage. Additionally, the clinical documentation does not support the need for an oral suspension of this medication. Therefore, continued use would not be indicated. The request for Deprizine 150mg/ml, 250 ml, is not medically necessary or appropriate.

**Dicopanol 5mg/ml, 150ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** The requested medication contains diphenhydramine. Official Disability Guidelines state that sedating antihistamines have been suggested as sleep aids; however, tolerance seems to develop within a few days. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. Therefore, continued use would not be supported. Additionally, the clinical documentation does not support the need for a liquid formulation for this patient. Also, there is

no adequate assessment of the patient's sleep hygiene to support the need for medication management of insomnia related to pain. The request for Dicopanol 5mg/ml, 150ml, is not medically necessary or appropriate.

**X-rays:** 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 10 Elbow Disorders (Revised 2007) Page(s): 242-243.

**Decision rationale:** The clinical documentation submitted for review does provide evidence that the patient is being treated conservatively with elbow support, activity modifications, physical therapy, medications and acupuncture. The American College of Occupational and Environmental Medicine do not generally recommend imaging studies unless the imaging study will change the outcome of treatment planning, there is suspicion of red flag conditions, or the patient has failed to progress in a rehabilitation program, surgical intervention is being considered. The clinical documentation submitted for review does not provide any evidence that the patient is a surgical candidate or has any red flag conditions. Additionally, the documentation does not address how additional imaging studies will assist in treatment planning. The request for X-rays is not medically necessary or appropriate.

**MRI for the elbow:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 242-243.

**Decision rationale:** The clinical documentation submitted for review does provide evidence that the patient is being treated conservatively with elbow support, activity modifications, physical therapy, medications and acupuncture. The American College of Occupational and Environmental Medicine do not generally recommends imaging studies unless the imaging study will change the outcome of treatment planning, there suspicion of red flag conditions, or the patient has failed to progress in a rehabilitation program, surgical intervention is being considered. The clinical documentation submitted for review does not provide any evidence that the patient is a surgical candidate or has any red flag conditions. Additionally, the documentation does not address how additional imaging studies will assist in treatment planning. The request for an MRI for the elbow is not medically necessary or appropriate.

**Physical therapy:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section Page(s): 98-99.

**Decision rationale:** The clinical documentation submitted for review does indicate that the patient has had previous physical therapy. California Medical Treatment Utilization Schedule recommends that patients be transitioned into a home exercise program to maintain improvements obtained during supervised skilled therapy. The clinical documentation submitted for review does not provide any evidence that the patient is participating in a home exercise program. Therefore, additional physical therapy would not be supported. The request for physical therapy is not medically necessary or appropriate.

**Chiropractic treatment, low back,:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Section Page(s): 58.

**Decision rationale:** The clinical documentation submitted for review does not provide any evidence that the patient has had chiropractic treatment in the past for this injury. Additionally, body part that the chiropractic treatment is being requested for is not defined within the request. California Medical Treatment Utilization Schedule does not recommend the use of manual therapy for the forearm, wrist and hand. The clinical documentation submitted for review does indicate that the patient has developed shoulder pain. This may benefit from chiropractic care. However, California Medical Treatment Utilization Schedule recommends a trial of 6 visits to establish the efficacy of treatment. The submitted request does not clearly define a treatment or duration. The request for Chiropractic treatment, low back, is not medically necessary or appropriate.

**TENS (transcutaneous electrical nerve stimulation):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Section Page(s): 114.

**Decision rationale:** The clinical documentation submitted for review does not provide any evidence that the patient previously underwent this type of therapy. California Medical Treatment Utilization Schedule recommends the use of a TENS unit be based on a 30 day home trial that established functional improvement and symptom relief. As there is no documentation that the patient has undergone a trial of treatment a TENS unit would not be indicated. The request for a TENS unit is not medically necessary or appropriate.

**hot/cold therapy unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guidelines Clearinghouse

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 228.

**Decision rationale:** The American College of Occupational and Environmental Medicine does recommend the application of hot/cold packs in the conservative management of a patient's pain. However, the clinical document submitted for review does provide evidence that the patient has previously applied this type of therapy without any pain relief or functional benefit. Therefore, continued use would not be indicated. The request for a hot/cold therapy unit is not medically necessary or appropriate.

**ESWT (extracorporeal shock wave therapy):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. 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) Elbow Chapter and Shoulder Chapter, Extracorporeal shock wave therapy (ESWT)

**Decision rationale:** Official Disability Guidelines do not recommend this type of therapy for elbow related injuries. Clinical documentation submitted for review does indicate that the patient has developed shoulder pain. However, Official Disability Guidelines only recommend this type of therapy for calcifying tendonitis. The clinical documentation submitted for review does not provide any evidence that the patient has a diagnosis of or symptoms supporting that they have calcifying tendonitis. The request for ESWT is not medically necessary or appropriate.