

<b>Case Number:</b>	CM14-0003523		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	02/24/2010
<b>Decision Date:</b>	05/27/2014	<b>UR Denial Date:</b>	01/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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 Orthopedic Surgery 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:

This 52-year-old female custodian sustained an industrial injury on 2/24/10. She is status post right carpal tunnel release on 7/16/13 and right shoulder arthroscopy in December 2010. The 11/21/13 treating physician report cited continued complaints of right elbow pain radiating to digits 4 and 5, moderate medial elbow pain, residual volar wrist pain, and bilateral 1st CMC joint pain and intermittent swelling. Pain was 7-8/10 without medications, and 5/10 with medications. Pain relief lasted 4-5 hours, allowing for restful sleep and ability to perform some light household chores. Right wrist/thumb exam documented positive grind Finkelstein's tests and tenderness over the volar wrist and 1st extensor compartment. Right elbow exam noted medial elbow tenderness, positive Tinel's with symptoms to digits 4 and 5, full range of motion with end-range pain, and positive reverse Cozen's. The diagnosis included right deQuervain's, 1st CMC osteoarthritis, cervical spine sprain/strain, C5/6 disc bulge with upper extremity radicular, right medial and lateral epicondylitis with mild cubital tunnel syndrome, and left shoulder sprain/strain. The treatment plan recommended continued home exercise and bracing, surgical consultation for right elbow, diagnostic ultrasound right elbow, and post-op chiropractic demo session for home exercise program with TheraPutty. Medications were dispensed including Norco for chronic pain, Prilosec for dyspepsia due to medications, Fexmid for spasms, and Dendracin for neuropathic pain. The elbow diagnostic ultrasound was requested for consideration of invasive treatment due to on-going joint and neurologic symptoms, positive electrodiagnostic findings of cubital tunnel syndrome, and failure of conservative treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRESCRIPTION OF NORCO (HYDROCODONE BIT/ACETAMINOPHEN) 10/325MG, #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-93. Decision based on Non-MTUS Citation Opioids.

**Decision rationale:** Under consideration is a request for a prescription of Norco (hydrocodonebit/acetaminophen) 10/325 mg, #120. The California MTUS guidelines support the use of hydrocodonebit/acetaminophen (Norco) for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Guidelines criteria have not been met. The patient presents with moderate pain levels with documented pain reduction attributed to her current medications. There is no evidence of overall improvement in function with this medication. Tapering has been recommended in upper extremity since 8/23/13. The 1/2/14 utilization review recommended this request be certified with modification to Norco 10/325 mg #84. There is no compelling reason presented to support the medical necessity of medication beyond that previously allowed. Therefore, this request for Norco 10/325 mg is not medically necessary.

**PRESCRIPTION OF PRILOSEC (OMEPRAZOLE) 20MG, #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS NSAIDS, GI Symptoms And Cardiovascular Risk, Chronic Pain Med. Decision based on Non-MTUS Citation MTUS: NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISK, CHRONIC PAIN MEDICAL TREATMENT GUIDELINES.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, Gastrointestinal (GI) Symptoms & Cardiovascular Risk Page(s): 68-69. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK, 68-69.

**Decision rationale:** Under consideration is a request for a prescription of Prilosec (omeprazole) 20mg, #30. The California MTUS guidelines recommend the use of a proton pump inhibitor, like Prilosec, in the treatment of dyspepsia secondary to NSAID therapy. The Official Disability Guidelines recommend the use of proton pump inhibitors for patients at risk for gastrointestinal events and indicate these medications should be used at the lowest dose for the shortest possible amount of time. Guideline criteria have not been met. The patient is not currently prescribed a non-steroidal anti-inflammatory drug. There is no documentation of current gastrointestinal symptoms or co-morbidities to support the medical necessity of this medication. Therefore, this request for Prilosec (omeprazole) 20mg, #30 is not medically necessary.

**UNKNOWN POST-OP CHIROPRACTIC TREATMENTS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

**Decision rationale:** Under consideration is a request for unknown post-op chiropractic treatment. The California MTUS schedule does not recommend chiropractic treatment for forearm, wrist, or hand injuries, or for carpal tunnel syndrome. Post-op physical therapy treatment is recommended following carpal tunnel release for a 3-month post-surgical treatment period. Guideline criteria have not been met. Records suggest that this care is for demonstration of hand exercises. The medical necessity for post-op exercise instruction beyond the post-surgical treatment period is not established. It is reasonable that exercise instruction was accomplished during the immediate post-operative period. The frequency/duration of this request is not specified. A functional treatment goal is not established. Therefore, this request for unknown post-op chiropractic treatment is not medically necessary.

**PRESCRIPTION OF FEXMID (CYCLOBENZAPRINE HCL) 7.5MG, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril),. Decision based on Non-MTUS Citation Cyclobenzaprine (Flexeril).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42. Decision based on Non-MTUS Citation Cyclobenzaprine (Flexeril).

**Decision rationale:** Under consideration is a request for one prescription of Fexmid (cyclobenzaprine HCL) 7.5mg, #60. The California MTUS guidelines recommend the use of non-sedating muscle relaxants with caution as a second-line option for short term treatment of acute exacerbations of chronic lower back pain. Fexmid is recommended as an option in the management of muscle spasms, but is not recommended to be used for longer than 2 to 3 weeks. Guideline criteria have not been met for the continued use of this medication. There is no current documentation of muscle spasms or specific functional benefit associated with the use of this medication. Additionally, records indicate that this medication has been used since for at least 2 months. Given the lack of guideline support for long-term use, continuation is not recommended. Therefore, this request for one prescription of Fexmid (cyclobenzaprine HCL) 7.5mg, #60 is not medically necessary.

**UNKNOWN EMS UNIT SUPPLIES: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Tens.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121.

**Decision rationale:** Under consideration is a request for unknown EMS unit supplies. Records suggest that the patient has used an OrthoStim unit in the past. The OrthoStim units provide a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines support the use of TENS in the first 30 days post-surgery. Galvanic stimulation is not recommended and considered investigational for all indications. Interferential current is not recommended in isolation. NMES is not recommended in chronic pain. Guideline criteria have not been met. Continued use of any form of transcutaneous electrotherapy is not supported by current documentation relative to specific unit, clinical indications, or past response. The use of a combination unit, when one of the electrotherapies is not recommended, is not recommended. Therefore, this request for unknown EMS unit supplies is not medically necessary.

**ONE DIAGNOSTIC ULTRASOUND OF THE RIGHT ELBOW:** 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) Elbow (Acute & Chronic)-Indications For Imaging-Ultrasound.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow, Ultrasound, Diagnostic.

**Decision rationale:** Under consideration is a request for diagnostic ultrasound of right elbow. The California MTUS guidelines are silent regarding diagnostic ultrasound. The Official Disability Guidelines indicate that diagnostic ultrasound is helpful for diagnosis of complete and partial tears of the distal biceps tendon, providing an alternative to MRI. There was low specificity noted in the detection of symptomatic lateral epicondylitis. Indications included suspicion of nerve entrapment or mass and biceps tendon tear and/or bursitis, when plain films are non-diagnostic. Guideline criteria have not been met. There is no reported suspicion of biceps tendon tear, bursitis, or mass. This patient has signs/symptoms consistent with the current diagnoses of medial/lateral epicondylitis and mild cubital tunnel syndrome which is confirmed by EMG/NCV. There is no compelling reason for additional diagnostic studies presented. Therefore, this request for diagnostic ultrasound of the right elbow is not medically necessary.

**ONE SURGICAL CONSULTATION WITH [REDACTED]:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 2. Decision based on Non-MTUS Citation Elbow Surgery Consultation, Chapter 10- Elbow Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 35. Decision based on Non-MTUS Citation American College Of Occupational And Environmental Medicine (ACOEM), 2nd Edition.

**Decision rationale:** Under consideration is a request for surgical consultation with [REDACTED]. This patient has been diagnosed with medial and lateral epicondylitis and mild cubital tunnel syndrome. The California MTUS guidelines state that referral for surgical consultation in elbow conditions may be indicated for patients who: have significant activity limitations for more than 3 months; failed to improve with exercise programs to increase range of motion and strength of the musculature around the elbow; or have clinical and electrophysiologic or imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. Guidelines state that there are no published random controlled trials that indicate surgery for medial and lateral epicondylitis improves the condition over non-surgical options. Guideline criteria have not been met. Electrodiagnostic studies documented mild cubital tunnel syndrome. There is no detailed documentation that comprehensive non-operative conservative treatment, including exercise, specifically directed to the elbow had been tried and failed. Therefore, this request for surgical consultation with [REDACTED] is not medically necessary.

**ONE PRESCRIPTION OF DENDRACIN TOPICAL LOTION 120ML:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** Under consideration is a request for one prescription of Dendracin topical lotion 120ml. Dendracin topical lotion contains capsaicin, menthol and methyl salicylate. The California Medical Treatment Utilization Schedule does not specifically address the use of Dendracin. The MTUS indicates that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines recommend the short term use (4-12 weeks) of non-steroidal anti-inflammatory agents (NSAIDs), such as methyl salicylate, for osteoarthritis and tendinitis, particularly of the knee and elbow or other joints that are amenable to topical treatment. Guidelines recommend capsaicin only in patients who have not responded or are intolerant of other treatments. Guideline criteria have not been met. There is no indication that this patient has not responded to or is intolerant of other treatments to support the use of capsaicin. There is no indication of the duration of use or what, if any, functional benefit has been achieved with use. Given the failure to meet guideline criteria for the use of all components in this compounded topical analgesic, this request for Dendracin topical lotion 120ml is not medically necessary.