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| <b>Case Number:</b>   | CM14-0186236 |                              |            |
| <b>Date Assigned:</b> | 11/14/2014   | <b>Date of Injury:</b>       | 01/20/2010 |
| <b>Decision Date:</b> | 12/31/2014   | <b>UR Denial Date:</b>       | 10/10/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/07/2014 |

### 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 & Rehabilitation and is licensed to practice in Wisconsin. 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 51-year-old male who reported an injury on 01/20/2010. The mechanism of injury was when the injured worker slipped and fell. The diagnoses included lumbago, lower back pain, cervical pain, and cervicgia. The previous treatments included medication and psychological evaluation. Within the clinical note dated 10/16/2014 it was reported the injured worker complained of lower back pain with radiation to the left leg with increased activity. He complained of neck pain and numbness to the arms and hands. He rated his pain 6/10 in severity without medication. The physical examination revealed pain in the S1 distribution; painful midline and paraspinal muscles; tenderness to the left paralumbar and tenderness to the right paralumbar spine. The examination of the bilateral upper extremities was noted to be normal appearance and stable. A request was submitted for an Elbow Compression Sleeve, Hydroxyzine, and Mobic. However, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Elbow Compression Sleeve:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

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

**Decision rationale:** The request for an elbow compression sleeve is not medically necessary. The Official Disability Guidelines not immobilization is not recommended as a primary treatment. Immobilization and rest appear to be overused as a treatment. Early immobilization benefits include early return to work with decreased pain and swelling and stiffness. There is lack of clinical documentation warranting the medical necessity for the request. Additionally, the guidelines do not recommend immobilization as a primary treatment. The guidelines note early immobilization benefits; however, the injured worker's date of injury was in 2010 which exceeds the treatment for early mobilization. Therefore, the request for Elbow Compression Sleeve is not medically necessary.

**Hydroxyzine 25mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/monograph/hydroxyzine-hydrochloride.html>

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

**Decision rationale:** The request for Hydroxyzine 25 mg #60 is not medically necessary. The Official Disability Guidelines state insomnia treatment is based on the etiology with the medication recommended. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbances. Failure of sleep disturbance to resolve in 7 to 10 day period may indicate a psychiatric or mental illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The clinical documentation submitted failed to indicate the injured worker is treated for insomnia. The request submitted failed to provide the frequency of the medication. The efficacy of the medication was not submitted for clinical review. Therefore, the request for Hydroxyzine 25mg #60 is not medically necessary.

**Mobic 15mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

**Decision rationale:** The request for Mobic 15 mg #30 is not medically necessary. The California MTUS Guidelines recommend nonsteroidal anti-inflammatory drugs at the lowest dose for the shortest period of time. The guidelines note NSAIDs are recommended for the signs

and symptoms of osteoarthritis. There is lack of documentation indicating the efficacy of medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request for Mobic 15mg #30 is not medically necessary.