

Case Number:	CM14-0048879		
Date Assigned:	06/25/2014	Date of Injury:	04/08/2004
Decision Date:	09/17/2014	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	03/27/2014

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 Occupational Medicine 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 is a 47 year old female with a 4/8/04 date of injury. She sustained a repetitive strain injury and felt a snap in the right forearm associated with severe pain and weakness in the arm. She was diagnosed with tennis elbow. In a more recent 6/19/10 report, the patient continues to have constant, dull, aching, burning right elbow and forearm pain that is aggravated by any repetitive activity. Objective findings include a well-healed lateral elbow incision; elbow ROM of 0 to 150 degrees, tenderness over the lateral epicondyle, and normal strength with resisted wrist and digital extension. In a recent progress note dated 8/29/14, the patient reports 4/10 pain with her current medication regimen (Oxycodone, Skelaxin) and 7/10 pain without it. MRI right elbow on 7/2004 showed evidence of lateral epicondylitis and edema but no tear. Right upper extremity EMG/NCS on 5/11/06 showed no evidence of peripheral nerve, plexus, or nerve root lesions. Right elbow x-rays on 7/28/04 were normal. Diagnostic Impression: right elbow lateral epicondylitis, chronic neuropathic pain syndrome. Treatment to date: right elbow lateral epicondylar debridement and partial osteotomy (9/2004), right elbow revision lateral epicondylar debridement and repair (11/1/05), right elbow excision of cutaneous neuroma (4/17/07), right elbow cortisone injections X 2, medication management (Skelaxin, Oxycodone), TENS unit, physical therapy, and home exercise. A prior UR decision dated 3/12/14 denied the request for right elbow cortisone injection on the basis that there is poor evidence of long-term benefit. The request for Skelaxin was denied on the basis that there is no evidence that this medication is useful in treating epicondylitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 right lateral epicondyle injection between 2/21/14 and 5/10/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 25. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33-40. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Elbow Chapter.

Decision rationale: The CA MTUS states that there is good evidence that glucocorticoid injections reduce lateral epicondylar pain. However, there is also good evidence that the recurrence rates are high. ODG recommends a single injection as a possibility for short-term pain relief in cases of severe pain from epicondylitis; but beneficial effects persist only for a short time, and the long-term outcome could be poor. In the present case, the patient appears to primarily be suffering from a chronic pain syndrome, and it is doubtful that a right elbow epicondylar injection would improve this complicated clinical picture. In addition, prior right elbow cortisone injections have been ineffective. Therefore, the request for 1 right lateral epicondyle injection between 2/21/14 and 5/10/14 is not medically necessary.

1 prescription for Skelaxin 800mg #30 with 1 refills between 2/21/14 and 5/10/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. In addition muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement, and no additional benefit has been shown when muscle relaxants are used in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In the present case, the patient has no history of low back pain or any documented evidence of muscle spasms in her right upper extremity. There is no evidence that muscle relaxants have a role in treating acute lateral epicondylitis, or in this case, chronic complicated lateral epicondylitis. Therefore, the request for 1 prescription for Skelaxin 800mg #30 with 1 refill between 2/21/14 and 5/10/14 is not medically necessary.