

<b>Case Number:</b>	CM15-0107290		
<b>Date Assigned:</b>	06/11/2015	<b>Date of Injury:</b>	05/02/2008
<b>Decision Date:</b>	07/17/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 54-year-old female, with a reported date of injury of 06/02/2008. The diagnoses include cervical discopathy, shoulder joint derangement, cubital tunnel syndrome, status post right lateral epicondylar release, and neck pain after neck surgery. Treatments to date have included an x-ray of the cervical spine which showed no implant failure, and good position and alignment; and oral medications. The progress report dated 05/19/2015 indicates that the injured worker had a history of neck pain, and the pain was improving. She also had constant pain in the bilateral shoulders, left greater than right, rated 7 out of 10; and bilateral elbows, right greater than left, rated 7 out of 10. The injured worker also complained of difficulty sleeping. The physical examination of the cervical spine showed tenderness to palpation of the paravertebral with spasm, negative axial loading compression test, limited range of motion with pain, and a well-healed scar. An examination of the elbows showed tenderness over the elbow about the olecranon groove, positive Tinel's sign over the cubital tunnel, full and painful range of motion, and diminished sensation in the ulnar digits. An examination of the shoulders showed tenderness around the anterior glenohumeral region and subacromial space, positive Hawkins and impingement signs, intact but painful rotator cuff function, and symptoms with internal rotation and forward flexion. The treating physician requested Tramadol ER (extended-release) 150mg #90, Ondansetron 8mg, Cyclobenzaprine 7.5mg, physical therapy to the elbows, and a battery for the bone stimulator. It was noted that the medications were being refilled, and that the injured worker was benefiting from the medications. The injured worker continued taking her medications as directed. It was also noted that the medications were helping in curing and

relieving the injured worker's symptoms, and were improving her activities of daily living, and made it possible for her to continue working and/or maintain the activities of daily living. The treatment plan was to continue the use of the bone stimulator.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Ondansetron 8mg quantity 30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Ondansetron (Zofran).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine (2014).

**Decision rationale:** Ondansetron (Zofran) is used to prevent nausea and vomiting that may be caused by anesthesia/surgery, or chemotherapy or radiation therapy. It is also approved for use acutely with gastroenteritis. Ondansetron is not used and is ineffective for nausea associated with narcotic analgesics. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

#### **Cyclobenzaprine 7.5mg quantity 120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

**Decision rationale:** According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. In this case, the available records show that the patient has not shown a documented benefit or any functional improvement from prior Cyclobenzaprine use. In addition, there is no clinical indication presented for the chronic or indefinite use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested medication is not medically necessary.

#### **Tramadol extended release 150mg quantity 90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to the California MTUS, Tramadol (Ultram) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. In this case, it is not clear what other medications/opiates have (or have not) been tried. Tramadol is not recommended as a first-line oral analgesic. In addition, there has been no documentation of the medication's functional improvement. Medical necessity for the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested treatment with Tramadol is not medically necessary.

**Physical Therapy to the elbows quantity 12:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Physical Therapy.

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. According to the ODG PT guidelines, up to 8 visits over 5 weeks for medial or lateral epicondylitis are indicated, contingent on objective improvement documented. For ulnar nerve entrapment/cubital tunnel syndrome, 14 visits over 6 weeks are indicated. As with any treatment, if there is no improvement after 2-3 weeks the protocol may be modified or re-evaluated. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, the patient has completed previous physical therapy sessions. There is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the requested additional 12 PT sessions. Medical necessity for the requested services have not been established. The requested services are not medically necessary.

**Battery for the bone stimulator:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back-Acute and Chronic, Bone Growth Stimulators.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Bone growth stimulator.

**Decision rationale:** In this case, there has been no documentation of the use of a bone stimulator. Therefore, the medical necessity of a battery for the bone stimulator has not been established. The requested item is not medically necessary.