

<b>Case Number:</b>	CM15-0194386		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	08/23/2014
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2015

### 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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

### 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 52 year old female, who sustained an industrial injury on 8-23-2014. Medical records indicate the worker is undergoing treatment for lateral epicondylitis and right ulnar nerve surgery on 6-1-2015. A recent progress report dated 9-1-2015, reported the injured worker complained of right elbow and arm pain and swelling, rated 6-7 out of 10. "Pain is made worse by range of motion and is alleviated by rest and Voltaren gel". Physical examination revealed right elbow full range of motion with some pain at terminal extension and mild lateral tenderness over the surgery site. Treatment to date has included an unknown number of physical therapy visits, Percocet and Voltaren gel. On 9-14-2015, the Request for Authorization requested Percocet 10-325mg #60, Voltaren gel and 12 sessions of physical therapy for the right elbow. On 9-21-2015, the Utilization Review noncertified the requests for Percocet 10-325mg #60, Voltaren gel and 12 sessions of physical therapy for the right elbow.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids.

**Decision rationale:** Percocet (Oxycodone with acetaminophen) is a short-acting opioid. Chronic pain guidelines and ODG do not recommend opioid except for short use for severe cases, not to exceed 2 weeks and Routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficulty weaning. Medical documents indicate that the patient has been on Percocet, in excess of the recommended 2-week limit. Additionally, indications for when opioids should be discontinued include if there is no overall improvement in function, unless there are extenuating circumstances. The treating physician document moderate pain but fails to demonstrate improvement on Percocet, least reported pain or functional improvement on the medication. As such, the request for Percocet 10/325mg #60 is not medically necessary.

**Voltaren gel:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

**Decision rationale:** MTUS and ODG recommend usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. VOLTAREN (DICLOFENAC) (RECOMMENDED FOR OA) MTUS specifically states for Voltaren Gel 1% (diclofenac) that is it Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Medical records do not indicate that the patient is being treated for osteoarthritis pain in the joints. Additionally, the records indicate that the treatment area would be for lateral epicondylitis. As such, the request for Voltaren gel is not medically necessary.

**12 sessions of physical therapy, right elbow:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine, and Postsurgical Treatment 2009, Section(s): Elbow & Upper Arm.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Physical therapy.

**Decision rationale:** California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. The ODG states Recommended Limited evidence. As with any treatment, if there is no improvement after 2-3 weeks the protocol may be modified or re-evaluated. See also specific physical therapy modalities by name. Women and patients who report nerve symptoms are more likely to experience a poorer short-term outcome after PT management of lateral epicondylitis. ODG Physical Therapy Guidelines Lateral epicondylitis/ Tennis elbow (ICD9 726.32): Medical treatment: 8 visits over 5 weeks; Post-surgical treatment: 12 visits over 12 weeks. The medical records state that the patient has already received physical therapy as recommended by the guidelines. There is no indication for further therapy given current limited disability. As such, the request for 12 session of physical therapy right elbow is not medically necessary.