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| <b>Case Number:</b>   | CM15-0015016 |                              |            |
| <b>Date Assigned:</b> | 02/03/2015   | <b>Date of Injury:</b>       | 01/04/2013 |
| <b>Decision Date:</b> | 03/25/2015   | <b>UR Denial Date:</b>       | 01/06/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/27/2015 |

### 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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

### 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 50 year old male, who sustained an industrial injury on 01/04/2013. He has reported pain in the lumbar spine and bilateral upper extremities. The diagnoses have included lumbar spine sprain/strain; bilateral elbow sprain/strain; bilateral elbow medial epicondylitis; and possible bilateral cubital tunnel syndrome. Treatment to date has included medications, injections, and physical therapy. Medications have included Anaprox, Fexmid, and Prilosec. A progress note from the treating physician, dated 12/15/2015, documented a follow-up visit with the injured worker. The injured worker reported low back pain with occasional radiation of pain to the right knee with numbness and tingling. Objective findings included tenderness to the paraspinal muscles with spasms of the lumbar spine; and tenderness to the bilateral medial epicondyle region. The treatment plan has included request for refill of medications; request for diagnostic ultrasound to the bilateral elbows; request EMG/ NCS of the bilateral upper extremities; and follow-up evaluation. On 01/06/2015 Utilization Review non-certified 1 prescription of Anaprox DS 550 mg#60; Prilosec 20 7.5 mg #60mg #30; Fexmid 7.5 mg #60; Bilateral diagnostic ultrasound of the elbows; and EMG (Electromyography)/ NCV (Nerve Conduction Velocity) studies of bilateral upper extremities. The CA MTUS and the ODG were cited. On 01/26/2015, the injured worker submitted an application for IMR for review of 1 prescription of Anaprox DS 550 mg#60; Prilosec 20 7.5 mg #60mg #30; Fexmid 7.5 mg #60; Bilateral diagnostic ultrasound of the elbows; and EMG (Electromyography)/ NCV (Nerve Conduction Velocity) studies of bilateral upper extremities.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Anaprox DS 550mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (non-steroidal anti-inflammatory drugs) Page(s): 67-73. Decision based on Non-MTUS Citation Pain (Chronic), Naproxen, NSAIDS (non-steroidal anti-inflammatory drugs)

**Decision rationale:** MTUS specifies four recommendations regarding NSAID use: 1) Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. 2) Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. 3) Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. 4) Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. The treating physician does not document failure of primary (Tylenol) treatment. Progress notes indicate the IW has been on naproxen for an extended period of therapy, MTUS guidelines recommend against long-term use. Radicular pain is present, but as MTUS outlines, the evidence for NSAID use in neuropathic pain is inconsistent and cannot be recommended. As such the request for anaprox 550 mg x60 is deemed not medically necessary.

**Prilosec 20 7.5mg #60mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs) GI (Gastrointestina).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Pain (Chronic), NSAIDS, GI symptoms & cardiovascular risk

**Decision rationale:** MTUS states "Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." The medical documents provided do not establish the patient has having documented GI bleeding/perforation/peptic ulcer or other GI risk factors as outlined in MTUS. Additionally, as the request for anaprox is not medically necessary the request for NSAID

prophylaxis is not indicated. As such, the request for prilosec 20mg is deemed not medically necessary.

**Fexmid 7.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63, 64, 41.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Medications for chronic pain, Antispasmodics Page(s): 41-42, 60-61, 64-66. Decision based on Non-MTUS Citation Pain, Cyclobenzaprine

**Decision rationale:** MTUS Chronic Pain Medical Treatment states for Cyclobenzaprine, "Recommended as an option, using a short course of therapy. . . The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief." The medical documents indicate that patient is far in excess of the initial treatment window and period. Additionally, MTUS outlines that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005)" Up to date "flexeril" also recommends "Do not use longer than 2-3 weeks". Medical documents do not fully detail the components outlined in the guidelines above and do not establish the need for long term/chronic usage of cyclobenzaprine. In fact this request alone exceeds a recommended duration of treatment. As such, the request for cyclobenzaprine 7.5mg #60 is deemed not medically necessary.

**Bilateral diagnostic ultrasound of the elbows:** Overtaken

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Official Disability Duration Guidelines, Treatment in Workers Compensation, ([http:// www.odg-twc.com/odgtwc/elbow.htm](http://www.odg-twc.com/odgtwc/elbow.htm))

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Elbow, ultrasound diagnostic

**Decision rationale:** ODG states; Ultrasound of the common extensor tendon had high sensitivity but low specificity in the detection of symptomatic lateral epicondylitis. (Levin, 2005) Limited evidence shows that diagnostic sonography may not be effective in predicting response to conservative therapy for tennis elbow. (Struijs, 2005). Indications for imaging Ultrasound (per ODG): Chronic elbow pain, suspect nerve entrapment or mass; plain films nondiagnostic

(an alternative to MRI if expertise available) Chronic elbow pain, suspect biceps tendon tear and/or bursitis; plain films nondiagnostic (an alternative to MRI if expertise available). The rationale provided for the ultrasound request is for diagnosis of cubital tunnel syndrome, which would meet the ODG indication for imaging. However, the clinical documentation does not provide a great deal of objective evidence as to why this diagnosis is being considered, epicondylitis is a more likely potential diagnosis. But given that US is a sensitive indicator of either diagnoses and a less expensive alternative for imaging than MRI it is reasonable to pursue US for a positive diagnosis. I am reversing the prior decision and find US of the bilateral elbows to be medically necessary.

**EMG (Electromyography)/ NCV (Nerve Conduction Velocity) studies of bilateral upper extremities:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Pain, Electrodiagnostic testing (EMG/NCS)

**Decision rationale:** ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia). The diagnosis of cubital tunnel syndrome is a potential indication for a limited EMG, however it is not an indication for a full upper extremity electrodiagnostic series. If there is an additional indication that this request is based on, it is either not provided, or not legible in the available medical record. As such the request for bilateral upper extremity EMG/NCS is deemed not medically necessary.