

<b>Case Number:</b>	CM15-0114127		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	06/10/2009
<b>Decision Date:</b>	08/31/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 (IW) is a 36-year-old female who sustained an industrial injury on 06/10/2009. Diagnoses include status post right lateral extensor origin repair with epicondylectomy and status post right medial extensor origin repair with epicondylectomy. Treatment to date has included medications, surgery, cortisone injections to the right elbow and right ulnar nerve block and physical therapy. According to the progress notes dated 5/18/15, the IW reported numbness in the right hand and pain in the right medial elbow. On examination, there was tenderness over the right medial flexor tendon origin. An ultrasound-guided right ulnar nerve block and cortisone injections to the right elbow were performed. A request was made for 12 session of occupational therapy, Prilosec 20mg, #60, Celebrex (unspecified) and a retrospective request for an ultrasound-guided ulnar nerve block (for date of service 5/18/15).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational therapy (12 sessions):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

**Decision rationale:** Based on the 05/18/15 progress report provided by treating physician, the patient presents with pain to right elbow and numbness in the right hand. The patient is status post right lateral epicondylectomy, secondary repair of the common extensor origin and anconeus muscle flap, and right medial epicondylectomy with debridement and secondary repair of the flexor pronator origin 09/26/14, and status post carpal tunnel syndrome 06/09/11. The request is for Occupational Therapy (12 Sessions). RFA dated 05/27/15 provided. Patient's diagnosis on 02/13/15 includes right forearm tendinitis. Physical examination to the right elbow on 02/13/15 revealed well healed scars to medial and lateral aspects of elbow. Mild tenderness noted to medial and lateral epicondyles. Range of motion -5 degrees on extension. Sensation diminished in the medial antebrachial cutaneous nerve distribution. Treatment to date has included surgery, cortisone injections to the right elbow and right ulnar nerve block, physical therapy, and medications. The patient is permanent and stationary, per 05/11/15 report. MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Patient's surgery to right elbow was on 09/26/14. RFA dated 12/24/14 stated request for 12 sessions of physical therapy for the diagnosis of "status post lat ex. origin, medical flexor origin repair." UR letter dated 06/02/15 states "12 session of treatment were certified in the last 3 months. There is no documentation of completion of these treatment sessions or outcome." This patient is no longer within postoperative treatment period. Given the patient's continued pain, a short course of physical therapy would appear to be indicated. However, per physical therapy note dated 01/05/15, the patient attended 14 visits. Treater has not documented efficacy of prior therapy. There is no explanation of why on-going therapy is needed, nor reason patient is unable to transition into a home exercise program. Furthermore, the request for 12 sessions would exceed what is allowed by MTUS. Therefore, the request is not medically necessary.

**Prilosec 20mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

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

**Decision rationale:** Based on the 05/18/15 progress report provided by treating physician, the patient presents with pain to right elbow and numbness in the right hand. The patient is status post right lateral epicondylectomy, secondary repair of the common extensor origin and anconeus muscle flap, and right medial epicondylectomy with debridement and secondary repair of the flexor pronator origin 09/26/14, and status post carpal tunnel syndrome 06/09/11. The request is for PRILOSEC 20MG, #60. RFA dated 02/16/15 provided. Patient's diagnosis on 02/13/15 includes right forearm tendinitis. Physical examination to the right elbow on 02/13/15

revealed well healed scars to medial and lateral aspects of elbow. Mild tenderness noted to medial and lateral epicondyles. Range of motion - 5 degrees on extension. Sensation diminished in the medial antebrachial cutaneous nerve distribution. Treatment to date has included surgery, cortisone injections to the right elbow and right ulnar nerve block, physical therapy, and medications. The patient is permanent and stationary, per 05/11/15 report. MTUS pg 69, NSAIDs, GI symptoms & cardiovascular risk Section states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. 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)." "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Prilosec has been included in RFA dated 02/16/15 and progress report 05/18/15. It is not known when Prilosec was initiated. Prophylactic use of PPI is indicated by MTUS, and the patient is on NSAID therapy, since she is also taking Celebrex. However, treater has not provided GI risk assessment for prophylactic use of PPI, as required by MTUS. Provided progress reports do not show evidence of gastric problems, and there is no mention of GI issues. Furthermore, the patient has been on this medication for at least 4 months from UR date of 06/02/15, and treater does not discuss how the patient is doing and why she needs to continue. Given lack of documentation, this request is not medically necessary.

**Celebrex (unspecified): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Selective COX-2 NSAIDS Page(s): 70.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Medications for chronic pain Page(s): 22, 60, 61.

**Decision rationale:** Based on the 05/18/15 progress report provided by treating physician, the patient presents with pain to right elbow and numbness in the right hand. The patient is status post right lateral epicondylectomy, secondary repair of the common extensor origin and anconeus muscle flap, and right medial epicondylectomy with debridement and secondary repair of the flexor pronator origin 09/26/14, and status post carpal tunnel syndrome 06/09/11. The request is for Celebrex (Unspecified). RFA with the request not provided. Patient's diagnosis on 02/13/15 includes right forearm tendinitis. Physical examination to the right elbow on 02/13/15 revealed well healed scars to medial and lateral aspects of elbow. Mild tenderness noted to medial and lateral epicondyles. Range of motion -5 degrees on extension. Sensation diminished in the medial antebrachial cutaneous nerve distribution. Treatment to date has included surgery, cortisone injections to the right elbow and right ulnar nerve block, physical therapy, and medications. The patient is permanent and stationary, per 05/11/15 report. MTUS guidelines page 22 supports NSAIDs for chronic LBP but for Celebrex, it states, "COX-2 inhibitors (e.g., Celebrex) may be considered if the patient has a risk of GI complications, but not for the majority of patients. Generic NSAIDs and COX-2 inhibitors have similar efficacy and risks when used for less than 3 months, but a 10-to-1 difference in cost." MTUS p 60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Celebrex has been included in patient's medications, per progress reports dated

01/15/15 and 05/18/15. It is not known when Celebrex has been initiated. NSAIDs are indicated by MTUS as first line treatment to reduce pain. However, Celebrex is not indicated for all patients, according to guidelines. Treater has not discussed GI complications, nor documented that the patient was previously prescribed other oral NSAIDs. There is no documentation of medication efficacy, and the quantity is not indicated in the request, either. Guidelines do not support open-ended requests. Given lack of documentation, this request is not medically necessary.

**RETRO: Ulnar nerve ultrasound guided nerve block (DOS: 5/18/15): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 22-24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (Acute & Chronic) Chapter under Ultrasound, diagnostic.

**Decision rationale:** Based on the 05/18/15 progress report provided by treating physician, the patient presents with pain to right elbow and numbness in the right hand. The patient is status post right lateral epicondylectomy, secondary repair of the common extensor origin and anconeus muscle flap, and right medial epicondylectomy with debridement and secondary repair of the flexor pronator origin 09/26/14, and status post carpal tunnel syndrome 06/09/11. The request is for Ulnar Nerve Ultrasound Guided Nerve Block (DOS: 5/18/15). RFA with the request not provided. Patient's diagnosis on 02/13/15 includes right forearm tendinitis. Physical examination to the right elbow on 02/13/15 revealed well healed scars to medial and lateral aspects of elbow. Mild tenderness noted to medial and lateral epicondyles. Range of motion -5 degrees on extension. Sensation diminished in the medial antebrachial cutaneous nerve distribution. Treatment to date has included surgery, cortisone injections to the right elbow and right ulnar nerve block, physical therapy, and medications. The patient is permanent and stationary, per 05/11/15 report. MTUS/ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10, Elbow update, pages 22- 24, under the topic Injections, for Corticosteroid injections states: "Quality studies are available on glucocorticoid injections and there is evidence of short-term benefits, but not long-term benefits. This option is invasive, but is low cost and has few side effects. Thus, if a non-invasive treatment strategy fails to improve the condition over a period of at least 3-4 weeks, glucocorticoid injections are recommended." ODG-TWC, Elbow (Acute & Chronic) Chapter under Ultrasound, diagnostic states: "Ultrasound guidance for injections: Not generally recommended. Conventional anatomical guidance by an experienced clinician is generally adequate." Per 05/18/15 report, treater states the patient is "eight months postop on the right...she reports numbness in the right hand and pain in the right medial elbow...the patient was given a nerve block to the right ulnar nerve followed by injection to the right medial elbow and medial flexor origin with 4 units of Celestone and 2mL of 0.5% Marcaine. This is done under ultrasound-guided needle placement." Per physical therapy note dated 01/05/15, the patient attended 14 visits. ODG and ACOEM do support trial of injections for short term relief to allow recovery from exercises and therapy. This request would appear to be reasonable given patient's postoperative, status, continued pain and diagnosis of right forearm tendinitis. However, treater intends continued physical therapy in conjunction with the requested

injection. Furthermore, ultrasound guidance is "not generally recommended" by guidelines since "Conventional anatomical guidance by an experienced clinician is generally adequate," per ODG. The request is not in accordance with guidelines. Therefore, this retrospective request is not medically necessary.