

Case Number:	CM15-0068932		
Date Assigned:	04/16/2015	Date of Injury:	12/03/2002
Decision Date:	06/05/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/10/2015

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: Emergency Medicine

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 60-year-old female, with a reported date of injury of 07/11/2009. The diagnoses include bilateral medial and lateral epicondylitis, ulnar nerve neuritis, bilateral joint inflammation, bilateral carpometacarpal joint inflammation, and chronic pain. Treatments to date have included oral medications, physical therapy, an MRI of the bilateral wrists, soft wrist braces, nerve studies, injections, and a transcutaneous electrical nerve stimulation (TENS) unit. The medical report dated 03/16/2015 indicates that the injured worker had quite a bit of tenderness along the ulnar nerve on both sides. The objective findings include limited abduction, tenderness along the biceps tendon on the right side, and weakness to resisted function. The treating physician requested Flexeril, lab test to include blood testing for liver and kidney function, x-rays of the right elbow, Ibuprofen, 1 hinged elbow brace, an interferential (IF) or muscle stimulator with conductive garment, and Lidoderm.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Flexeril 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine Page(s): 41-42.

Decision rationale: According to CA MTUS, cyclobenzaprine is recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. The IW has been receiving this prescription for a minimum of 12 months according to submitted records. This greatly exceeds the recommended timeframe of treatment. In addition, the request does not include dosing frequency or duration. The IW's response to this medication is not discussed in the documentation. The request is not medically necessary.

One lab to include blood testing for liver and kidney function: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Blood test for Liver and Kidney Function (pre-surgical).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, specific drug list & adverse effects Page(s): 70.

Decision rationale: The MTUS provides direction for some kinds of testing as monitoring of medication toxicity. Per the FDA recommendations, patients taking NSAIDS should have periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). This injured worker has been using a non-steroidal anti-inflammatory agent for greater than 6 months. Testing as per the FDA recommendations would be indicated. However, the requested test is a hepatic panel, which implies some number and variety of tests to assess aspects of the liver. The request is also for kidney function. This also may include a variety of tests beyond those in the aforementioned chemistry profile. As requested, the "liver panel" and "kidney function" could include a large variety of tests, some of which may not be indicated. As requested, the requests are not medically necessary because the contents of the panel were not defined.

One x-ray of the right elbow to include AP and lateral views: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, (Elbow, Acute & Chronic) X-ray AP, Lateral right elbow.

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

Decision rationale: The CA MTUS guidelines cited above recommend against radiographic imaging for ongoing, chronic elbow symptoms. The IW does not have an acute injury or concern for a diagnosed fracture or dislocation. According to the ODG guidelines cited, plain x-ray of the elbow may be diagnostic for osteochondral fracture, osteochochritis dissecans, and

osteocartilaginous intra-articular body. The submitted document does not include these diagnoses in the working differential. Without this supporting documentation and the chronicity of the IW process, the request for radiographic imaging of the right elbow is not medically necessary.

One prescription of Ibuprofen 800mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 65-66.

Decision rationale: According to CA MTUS chronic pain guidelines, non-steroidal anti-inflammatory agents are "recommended as an option for short term symptomatic relief" for the treatment of chronic low back pain. Further recommendations are for the lowest dose for a minimal duration of time. Specific recommendations for ibuprofen (Motrin) state, "sufficient clinical improvement should be observed to offset potential risk of treatment with the increase dose." The documentation does not support improvement of symptoms with NSAIDs currently prescribed. Additionally, the request does include frequency and dosing of this medication. The request is medically not necessary.

One hinged elbow brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Elbow Acute & Chronic, Elbow brace.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 2, 41-43.

Decision rationale: Documentation submitted dated 9/25/2014 states IW was given a hinged elbow brace. This documentation does not report which elbow. Documentation from 8/27/2014 states the IW was approved for "hinged elbow braces." The current request does not discuss use of these previous braces, symptom improvement from braces, or what necessitates replacement. The request does not indicated for which elbow the brace is requested and the IW has bilateral elbow complaints. Without this information, the request for one hinged elbow brace is not medically necessary.

One IF or muscle stimulator with a conductive garment: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation Page(s): 113-114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow - Transcutaneous electrical neurostimulation.

Decision rationale: CA MTUS and ODG state Transcutaneous electrical neuro-stimulation units are not recommended for elbow injuries. ODG guidelines states "No scientifically proved efficacy in the treatment of acute hand, wrist or forearm symptoms. Insufficient evidence exists to evaluate many physical modalities used to treat disorders of the elbow." Within these guidelines, the request is not medically necessary.

One prescription of Lidoderm #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patch Page(s): 56-57.

Decision rationale: CA MTUS is recommended for localized peripheral pain after there has been evidence of a trial of first line therapy such as a tricyclic, serotonin-norepinephrine reuptake inhibitor, or gabapentin. This medication is "not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia." There is not documentation to support the failure of this first line agent or intolerance of this medication. Additionally, the request does not include the location and frequency of application. As such, the request for lidoderm patches is not medically necessary.