

<b>Case Number:</b>	CM13-0053865		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	07/03/2013
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 46-year-old female with a 7/3/13 date of injury. The mechanism of injury occurred when he was pulling bundles of files off a cart and felt a bad sharp pain in right elbow. The only provider reports provided for review were urine toxicology reviews dated 11/18/13 and 12/26/13. According to the doctor's first report of occupational injury, dated 8/16/13, the patient complained of "was lifting something heavy and felt a sharp pain in right elbow" and reported pain for one month. An X-ray of the right elbow on 8/16/13 revealed no fracture or osseous lesion of right elbow, unremarkable exam. An MRI report of the right wrist, dated 12/2/13, revealed subchondral cyst formation present within the lunate, triquetrum, and capitate. An NCV of the bilateral upper extremities report, dated 2/11/14, revealed electrophysiological evidence of bilateral mild carpal tunnel syndrome. An MRI report of the right elbow, dated 5/19/14, revealed lateral epicondylitis. Objective findings: positive tenderness to palpations of lateral epicondyle, limited flexing and extension. Diagnostic impression: right elbow contusion/right epicondylitis. Treatment to date: not provided in documentation. A UR decision dated 10/25/13 denied the requests for compounded Ketoprofen, compounded Cyclopene, Fanatrex, x-ray, MRI, EMG/NCV, TENS unit, DME: hot/cold, FCE, shockwave, and acupuncture. Regarding Ketoprofen, there is no documentation that the claimant cannot utilize oral NSAID medications. Regarding compounded Cyclopene, there is no documentation of spasm for this claimant, and there is no documentation that this claimant cannot utilize oral dosage formulations of pain medications. Regarding Fanatrex, the injured employee has no complaints or physical examination findings of neuropathic pain. Regarding X-ray, this request does not specify what part is to be x-rayed. Regarding MRI, this request does not specify what body part the provider requests and MRI of and the employee has yet to participate in any kind of conservative treatment whatsoever. Regarding EMG/NCV, this request does not specify which body part is to

be tested. It could be assumed it is the right upper extremity, however, this is not specified in the request. Regarding TENS unit, the California MTUS specifically states that a TENS unit is to be used for neuropathic pain, the injured employee's description of symptoms is somewhat vague regarding neuropathy and there is a normal neurological physical examination. Regarding Hot/Cold unit, it is not specified which body part is to be treated. Regarding FCE, it is unclear why functional capacity evaluation is ordered prior to the employee participating in any treatment. Regarding shockwave therapy, the employee has yet to participate in any other type of conservative care. Regarding acupuncture, there is no mention that the patient's oral pain medications are reduced or not tolerated, or as an adjunct and postoperative care.

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

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

**Acupuncture:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Clinical Topics. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function Chapter, page 114

**Decision rationale:** The California MTUS/ACOEM guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician is paramount. In addition, Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Furthermore, guidelines state that time to produce functional improvement of 3 - 6 treatments. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. In addition, this request does not specify the area of the body to be treated. The number of acupuncture sessions requested is not noted. Therefore, the request for acupuncture is not medically necessary.

**Durable Medical Equipment (DME): Hot/Cold:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold

**Decision rationale:** The California MTUS and Official Disability Guidelines do not address this issue. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device),

the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. In addition, there is no documentation that this patient has had a trial and failure of standard hot/cold packs. A specific rationale as to why this patient requires a hot/cold unit was not provided. Therefore, the request for durable medical equipment: hot/cold is not medically necessary.

**TENS UNIT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 114-116.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines state that TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. Criteria for the use of TENS unit include Chronic intractable pain - pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. There is no documentation of the patient's treatment to date, including failure of other pain modalities. A specific rationale as to why this patient requires a TENS unit at this time was not provided. Therefore, the request for TENS Unit is not medically necessary.

**Electromyography (Extremity Unspecified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238, Table 10-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter - EMG

**Decision rationale:** The California MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. There is no documentation of radiculopathy or that this patient has had a failure of conservative therapy. In addition, the specific body part in which the provider has requested an EMG study is not specified in this request. Therefore, the request for Electromyography (Extremity Unspecified) is not medically necessary.

**Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Clinical Topics. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Independent Medical Examinations and Consultations, page(s) 132-139 and Official Disability Guidelines (ODG) Fitness for Duty Chapter - FCE

**Decision rationale:** The California MTUS states that there is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace; an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's abilities. In addition, Official Disability Guidelines states that an FCE should be considered when case management is hampered by complex issues (prior unsuccessful RTW attempts, conflicting medical reporting on precautions and/or fitness for modified job), injuries that require detailed exploration of a worker's abilities, timing is appropriate (Close to or at MMI/all key medical reports secured), and additional/secondary conditions have been clarified. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. There is no documentation of the patient's work description and what type of activity level is required at work. In addition, there is no description of the patient wanting to return to work at this time or that she has had difficulty returning to work. Therefore, the request for Functional Capacity Evaluation is not medically necessary.

**Compounded Ketoprofen 20%, 120gr: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 25, 28, 111-113.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines state that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and Gabapentin and other anti-epilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. In addition, guidelines do not support the use of the NSAID, Ketoprofen, in a topical formulation. A specific rationale identifying why this topical compounded medication would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Compounded Ketoprofen 20%, 120gr is not medically necessary.

**Magnetic Resonance Imaging (MRI): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254, Table 1. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter

**Decision rationale:** MTUS criteria for hand/wrist MRI include normal radiographs and acute hand or wrist trauma or chronic wrist pain with a suspicion for a specific pathology. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. In addition, the specific body part in which the provider has requested an MRI study is not specified in this request. An MRI report of the right elbow, dated 5/19/14, revealed lateral epicondylitis. It is unclear if the provider is requesting a repeat MRI or a new MRI of a different body part. There is no documentation of a significant change in the patient's condition since the previous MRI to warrant the need for repeat imaging. Therefore, the request for Magnetic Resonance Imaging (MRI) is not medically necessary.

**Shockwave:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

**Decision rationale:** The California MTUS states that quality studies are available on extracorporeal shockwave therapy in acute, subacute, and chronic lateral epicondylalgia patients and benefits have not been shown. This option is moderately costly, has some short-term side effects, and is not invasive. Thus, there is a strong recommendation against using extracorporeal shockwave therapy. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. The requesting provider failed to establish circumstances that would warrant ESWT despite strong adverse evidence. In addition, there is no documentation of prior conservative measures of therapy that have been tried and failed. Therefore, the request for Shockwave is not medically necessary.

**X-ray:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter - Radiography

**Decision rationale:** The California MTUS does not specifically address this issue. According to Official Disability Guidelines, Radiography is recommended as indicated for acute hand or wrist trauma or chronic wrist pain, first study obtained in patients with chronic wrist pain with or without prior injury, no specific area of pain specified. For most patients with known or suspected trauma of the hand, wrist, or both, the conventional radiographic survey provides adequate diagnostic information and guidance to the surgeon. When initial radiographs are equivocal, or in the presence of certain clinical or radiographic findings, further imaging is appropriate. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. In addition, the specific body part in which the provider has requested an X-ray is not specified in this request. An X-ray of the right elbow on 8/16/13 revealed no fracture or osseous lesion of right elbow, unremarkable exam. It is unclear if the provider is requesting a repeat X-ray or a new X-ray of a different body part. There is no documentation of a significant change in the patient's condition since the previous X-ray to warrant the need for repeat imaging. Therefore, the request for X-ray is not medically necessary.

**Compounded Cyclopene 5%, 120gr:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 25, 28, 111-113.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines state that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and Gabapentin and other anti-epilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. According to the UR decision dated 10/25/13 this medication is mainly cyclobenzaprine plus other proprietary ingredients. However, guidelines do not support the use of the muscle relaxant, Cyclobenzaprine, in a topical formulation. A specific rationale identifying why this topical compounded medication would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Compounded Cyclopene 5%, 120gr is not medically necessary.

**Fanatrex (Gabapentin) 25MG/ML, 420ML:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epileptic Drugs; Gabapentin Page(s): 16-18; 49. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Neurontin)

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines states that Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy

and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. According to the UR decision dated 10/25/13, Fanatrex is an oral suspension form of Gabapentin. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. There is no documentation that this patient has a neuropathic component to his pain. There is no documentation of subjective complaints or objective findings indicative of neuropathy. In addition, there is no documentation why this patient would require a specialized liquid form of Gabapentin as opposed to the standard tablet formulation. Therefore, the request for Fanatrex (Gabapentin) 25 MG/ML, 420ml is not medically necessary.

**Nerve Conduction Velocity Studies (Extremity Unspecified): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238, Table 10-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter - NCV

**Decision rationale:** The California MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. However, in the present case, there are no current progress reports provided for review to assess the patient's current condition. There is no documentation of radiculopathy or that this patient has had a failure of conservative therapy. In addition, the specific body part in which the provider has requested an NCV study is not specified in this request. Therefore, the request for Nerve Conduction Velocity Studies (Extremity Unspecified) is not medically necessary.