

<b>Case Number:</b>	CM13-0072466		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	11/19/2012
<b>Decision Date:</b>	04/21/2014	<b>UR Denial Date:</b>	12/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 patient with a date of injury of 11/19/12. A utilization review determination dated 12/6/13 recommends non-certification of PT, chiropractic, acupuncture, UA, shockwave therapy, LINT, and topical medications. It references an 11/11/13 medical report identifying 4 injections with just a little improvement. Constant sharp pain going up his back worsens with any bending, and there is shoulder pain. He has a lot of stress and is sometimes depressed. On exam, there is limited ROM in the lumbar spine and soreness at L4-5.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PHYSICAL THERAPY FOR LUMBAR SPINE AND RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

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

**Decision rationale:** Regarding the request for physical therapy for lumbar spine and right shoulder, California MTUS cites that "patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Within the documentation available for review, there is documentation of completion of

prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions or remaining functional deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested physical therapy for lumbar spine and right shoulder is not medically necessary.

**CHIROPRACTIC CARE FOR LUMBAR SPINE AND RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, Chronic Pain Treatment Guidelines Page(s): 58-60.

**Decision rationale:** Regarding the request for chiropractic for lumbar spine and right shoulder, CA MTUS Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain and there is also some support for its use in patients with frozen shoulder. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, there is no clear documentation of functional deficits or a frozen shoulder and the provider's request exceeds the 6 sessions recommended by the CA MTUS. Unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested chiropractic for lumbar spine and right shoulder is not medically necessary.

**ACUPUNCTURE SESSIONS FOR LUMBAR SPINE AND RIGHT SHOULDER:** 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-TWC) 10th edition 2012 (7/6/12), Low Back Chapter, Shock Wave Therapy

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain, with additional use supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions... and a reduction in the dependency on continued medical treatment." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, there is documentation of prior acupuncture treatment, but no documentation of functional improvement as defined above. In light of the above issues, the currently requested acupuncture is not medically necessary.

**URINALYSIS (UA)-DRUG COMPLIANCE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79, 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79, 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter Urine Drug Testing

**Decision rationale:** Regarding the request for UA-drug compliance, CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, there is no documentation of the date and results of prior testing and current risk stratification to support the requested frequency of testing. In light of the above issues, the currently requested UA-drug compliance is not medically necessary.

**SHOCKWAVE THERAPY FOR LUMBAR SPINE AND RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Shock wave therapy

**Decision rationale:** Regarding the request for shockwave therapy for lumbar spine and right shoulder, California MTUS supports this treatment for calcifying tendinitis of the shoulder, which has not been documented. Additionally, ODG notes that it is not recommended for the low back. In light of the above issues, the currently requested shockwave therapy for lumbar spine and right shoulder is not medically necessary.

**LINT FOR LUMBAR SPINE AND RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines 2nd Edition, Updated Chronic Pain Chapter (Revised 2008); Table 2 Summary of Recommendations for Managing Chronic Pain Conditions, p. 27

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** Regarding the request for LINT, California MTUS guidelines do support the use of some types of electrical stimulation therapy for the treatment of certain medical disorders. However, regarding LINT specifically, a search of the CA MTUS, ACOEM, ODG, National Library of Medicine, National Guideline Clearinghouse, and other online resources

failed to reveal support for its use in the management of the cited injuries. Additionally, no documentation was provided identifying that this treatment provides improved outcomes as compared to other treatment options that are evidence-based and supported, and there is no documentation identifying the medical necessity of this request. In the absence of such documentation, the currently requested LINT is not medically necessary.

**PRESCRIPTION OF TOPICAL CREAM: TRAMADOL /GABAPENTIN /CYCLOBENZAPRINE/ LIDOCAINE 7%/7%/5%/4% (120GM): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

**Decision rationale:** Regarding the request for topical cream: Tramadol /Gabapentin /Cyclobenzaprine/ Lidocaine 7%/7%/5%/4% (120gm), California MTUS cites that topical lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." That has not been documented. Furthermore, it is supported only as a dermal patch. Muscle relaxants and antiepilepsy drugs are not supported by the CA MTUS for topical use. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the currently requested topical cream: Tramadol /Gabapentin /Cyclobenzaprine/ Lidocaine 7%/7%/5%/4% (120gm) is not medically necessary.

**PRESCRIPTION OF TOPICAL CREAM: FLURBIPROFEN / CAPSAICIN / MENTHOL / CAMPHOR / 10%, 0.025%, 2%, 1% (120GM): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

**Decision rationale:** Regarding the request for topical cream: Flurbiprofen / Capsaicin / Menthol / Camphor / 10%, 0.025%, 2%, 1% (120gm), California MTUS cites that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." That has not been documented. Capsaicin is "Recommended only as an option in patients who have not responded or are intolerant to other treatments." That has not been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the currently requested topical cream:

Flurbiprofen / Capsaicin / Menthol / Camphor / 10%, 0.025%, 2%, 1% (120gm) is not medically necessary.