MAXIMUS Federal Services

Case Number:	CM14-0007068		
Date Assigned:	02/07/2014	Date of Injury:	02/10/2013
Decision Date:	07/25/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/15/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

The patient is a 34-year-old male who has filed a claim for hand and wrist fracture status post open reduction internal fixation and left lateral epicondylitis associated with an industrial injury date of February 10, 2013. Review of progress notes indicates left wrist pain with pins and needles in the left hand. Patient also reports triggering of the left ring and long fingers, and aching pain in the left forearm with some weakness. Findings include tenderness over the left forearm with flexion and extension of the left wrist; tenderness over the lateral epicondyle; pain over the metacarpophalangeal joint of the third and fourth digits with reproducible triggering; slightly decreased wrist range of motion, and decreased grip strength. CT of the bilateral wrists dated June 17, 2013 showed evidence of new bone formation and callus development at the fracture site with intact hardware; mild diffuse osteopenia of the left wrist; and abnormal alignment at bilateral distal radioulnar joints. Patient is on modified work. Electrodiagnostic study of the upper extremities dated November 25, 2013 showed mild left carpal tunnel syndrome. Treatment to date has included Tylenol, opioids, topical analgesics, Toradol injection, physical therapy, home exercises, and left hand/wrist surgery with ORIF in March 2013.Utilization review from December 27, 2013 denied the requests for physical therapy as there was no documentation of the operative procedure and quantity of post-op PT sessions already attended; extracorporeal shockwave therapy for the left elbow as this is not recommended; FluriFlex 15/10% cream and TGIce 8/10/2/2% 180g cream as these compounds are not recommended for topical application; and retrospective urine drug screen as there was no documentation of suspected illegal drug use, or prescription medication abuse.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy to the left upper extremity, elbow, hand and wrist (freq/duration unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

Decision rationale: Page 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment. Patient has had post-operative physical therapy sessions, and progress notes indicate that the patient did not complete the 24 visits that were initially requested. However, there is no documentation with regards to the functional benefits derived from these sessions. The patient is currently able to perform home exercises. Also, the requested frequency and duration of PT sessions are not specified. Therefore, the request for physical therapy to the left upper extremity, elbow, hand, and wrist was not medically necessary.

Extracorporeal shockwave therapy for lateral epicondylitis, left elbow: 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) ELBOW CHAPTER, EXTRACORPOREAL SHOCKWAVE THERAPY (ESWT).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) ELBOW CHAPTER, EXTRACORPOREAL SHOCKWAVE THERAPY (ESWT).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, extracorporeal shockwave therapy is not recommended, as there is conflicting evidence regarding its efficacy. Although the patient presents with persistent elbow pain, this procedure is not recommended. Therefore, the request for extracorporeal shockwave therapy for lateral epicondylitis, left elbow was not medically necessary.

Fluriflex 15/10% 180gm transdermal cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHAPTER TOPICAL ANALGESICS Page(s): 111 & 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

Decision rationale: Fluriflex contains flurbiprofen 10% and cyclobenzaprine 10%. According to CA MTUS Chronic Pain Medical Treatment Guidelines pages 111-113, any compounded product that contains at least one drug (or drug class) that is not recommend is not recommended. Cyclobenzaprine is not recommended for use as a topical analgesic. In addition, there is little to no research as for the use of flurbiprofen in compounded products. There is no documentation regarding intolerance to or failure of oral pain medications. There is no discussion regarding the need for variance from the guidelines. Therefore, the request for Fluriflex 15/10% 180 gm transdermal cream was not medically necessary.

Tgice 8/10/2/2% 180gm transdermal cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHAPTER TOPICAL ANALGESICS Page(s): 111 & 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN SECTION, TOPICAL SALICYLATES.

Decision rationale: TGIce contains tramadol/gabapentin/menthol/camphor 8%/10%/2%/2%. As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. CA MTUS does not support the use of both opioid medications and gabapentin in a topical formulation. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, camphor, or capsaicin, may in rare instances cause serious burns. There is no documentation regarding intolerance to or failure of oral pain medications. There is no documentation indicating the need for variance from the guidelines. Therefore, the request for TGIce transdermal cream 8/10/2/2% 180g was not medically necessary.

Retrospective urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: As stated on page 78 of the California MTUS Chronic Pain Medical Treatment Guidelines, urine drug screens are recommended as an option to assess order use or presence of illegal drugs and as ongoing management for continued opioid use. There is no documentation regarding use of opioid medications, or suspicion of illegal drug use, to support

this request. Therefore, the retrospective request for urine drug screen was not medically necessary.