

<b>Case Number:</b>	CM14-0103380		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	10/31/2011
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	06/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Ohio. 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 injured worker is a 55-year-old female who reported an injury on 05/01/2014 secondary to a fall. The current diagnoses include thoracic musculoligamentous sprain, lumbosacral sprain, right shoulder strain, right shoulder tendinosis, right shoulder adhesive capsulitis, right lateral epicondylitis, right carpal tunnel syndrome, right wrist pain, left knee strain, status post left knee surgery, left knee pain, acid reflux and indigestion, depression, and sleep disturbance. The injured worker was evaluated on 05/01/2014. Previous conservative treatment is noted to include physical therapy, extracorporeal shockwave therapy, bracing, transcutaneous electrical nerve stimulation (TENS) unit therapy, injections, and home exercise. The injured worker is also noted to have undergone electrodiagnostic studies in 02/2013, as well as a lumbar MRI in 09/2013. The injured worker presented with complaints of persistent pain over multiple areas of the body, as well as depression. Physical examination on that date revealed grade 3 tenderness to palpation over the paraspinals muscles, palpable muscle spasm, restricted thoracic and lumbar range of motion, positive straight leg raising bilaterally, trigger points, grade 3 tenderness to palpation of the right shoulder and wrist, and tenderness to palpation of the right knee with positive McMurray's testing. The injured worker reported an improvement in symptoms with physical therapy. Treatment recommendations at that time included continuation of physical therapy twice per week for 6 weeks and prescriptions for Fluriflex cream, TGHOT cream, Cyclobenzaprine 7.5 mg, Motrin 600 mg, Norco 5/325 mg, and extracorporeal shockwave therapy for the lumbar spine. A Request for Authorization form was then submitted on 05/01/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motrin 600 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's , Back Pain- Chronic Low Back Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. The injured worker does not maintain a diagnosis of osteoarthritis. There is no documentation of an acute exacerbation of chronic pain that has not responded to first line treatment with acetaminophen. There is also no frequency listed in the request. As such, the request is not medically appropriate.

**Norco 5/325 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. There is no documentation of a failure to respond to nonopioid analgesics. There is also no frequency listed in the request. As such, the request is not medically appropriate.

**Extracorporeal shockwave therapy to the lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-Low Back chapter- Shock Wave Therapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. There are no guideline recommendations for extracorporeal shockwave therapy for the lumbar spine. There is also no documentation of objective functional improvement following the initial course of extracorporeal shockwave therapy. There is no frequency or total duration of treatment listed in the request. As such, the request is not medically appropriate.

**Physical Therapy to cervical spine, left wrist and right knee:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. There is no documentation of objective functional improvement following the initial course of physical therapy. There is also no frequency or total duration of treatment listed in the current request. As such, the request is not medically appropriate.