

<b>Case Number:</b>	CM14-0130995		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	08/18/2009
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	07/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 42-year-old female with a reported date of injury on August 18, 2009. The injury reportedly occurred when the injured worker was hit in the right elbow by a door. Her diagnoses were noted to include carpal tunnel syndrome, carpal sprain/strain, trigger finger, elbow sprain/strain, and shoulder sprain/strain. Her previous treatments were noted to include acupuncture, occupational therapy, steroid injections, and carpal tunnel release. The progress note dated July 07, 2014 revealed complaints of right wrist pain rated 7/10, right elbow pain rated 6/10 to 7/10 and right shoulder pain rated 5/10. The injured worker complained of a loss of sleep. The physical examination noted pain to the right wrist area with range of motion. There was July 07, 2014 was for a UA for drug screen toxicology; MRA of the right shoulder, right elbow, right wrist, right hand for pain; however, the provider's rationale was not submitted within the medical records for a nerve conduction velocity to the bilateral upper extremities; extracorporeal shockwave therapy to the right upper extremity (ortho shockwave); tennis elbow support, gabapentin (10%), lidocaine (5%), tramadol (15%); and cyclobenzaprine (2%), tramadol (10%), flurbiprofen (20%).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Urinalysis (UA): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug therapy, Opioids, Steps to Avoid Misuse/Abuse Page(s): 43, 94.

**Decision rationale:** The request for a UA is not medically necessary. The injured worker complains of pain to the right hand, elbow, and shoulder. The California Chronic Pain Medical Treatment Guidelines recommend using a urine drug screen to assess for the use or presence of illegal drugs. The guidelines state for those at risk of abuse to perform frequent random urine toxicology screens. There was a lack of documentation regarding medications the injured worker is utilizing in regards to opioids to necessitate a urinalysis. A urinalysis was performed May 07, 2014; however, was not for urine toxicology screening. Therefore, due to the lack of medication regimen and the rationale not submitted for a urinalysis, the urinalysis is not appropriate at this time. Therefore, the request is not medically necessary.

**Magnetic Resonance Arthrography (MRA) of the 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, Shoulder Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Arthrography.

**Decision rationale:** The request for an MRA to the right shoulder is not medically necessary. The injured worker complained of right shoulder pain. The California MTUS/ACOEM Guidelines state arthrography is optional for preoperative evaluation of small full thickness tears. Magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because it demonstrates soft tissue anatomy. Selecting an imaging test takes into consideration any injured worker allergies to contrast materials (used in arthrography or contrast computed tomography), or concerns about claustrophobia and costs. Routine arthrography for evaluation of shoulder disorders without surgical indications is not indicated. The Official Disability Guidelines state subtle tears that are full thickness are best imaged by arthrography, whereas larger tears and partial thickness tears are best defined the MRI. Conventional arthrography can diagnose most rotator cuff tears accurately; however, in most institutions, MR arthrogram is usually necessary to diagnose labral tears. There is a lack of documentation regarding conservative treatment specifically to the right shoulder or previous imaging studies performed. The guidelines recommend arthrography to diagnose labral tears; however, there is a lack of clinical findings to diagnose a possible labral tear. Therefore, the request is not medically necessary.

**Nerve Conduction Velocities (NCV) of the Bilateral Upper Extremities: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Nerve Conduction Studies.

**Decision rationale:** The request for a nerve conduction velocity to the bilateral upper extremity is not medically necessary. The injured worker had a previous nerve conduction velocity test performed October 2010. The Official Disability Guidelines do not recommend nerve conduction studies to demonstrate radiculopathy if radiculopathy has already been clearly defined by a electromyography and obvious clinical signs, but recommended if electromyography is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies of non-neuropathic processes if other diagnoses may be likely based on the clinical examination. There is minimal justification for performing nerve conduction studies when an injured worker is already presumed to have symptoms on the basis of radiculopathy. Not all cervical electrodiagnostic studies are necessary to demonstrate a cervical radiculopathy. They have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than cervical radiculopathy, with caution that the studies can result in unnecessary overtreatment. The injured worker had a nerve conduction velocity performed October 2010, which showed no evidence of entrapment neuropathy or peripheral neuropathy. There is a lack of documentation regarding significant neurological deficits within a specific dermatomal distribution to warrant a repeat nerve conduction velocity. Therefore, the request is not medically necessary.

**Gabapentin (10%), Lidocaine (5%), and Tramadol (15%): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Lidocaine, Tramadol, Gabapentin Page(s): 111, 112, 82, 113.

**Decision rationale:** The request for gabapentin (10%), lidocaine (5%), and tramadol (15%); is not medically necessary. The injured worker complains of right shoulder, elbow, wrist, and hand pain. The California Chronic Pain Medical Treatment Guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. The guidelines primarily recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED, such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. The guidelines indicate the

formulation of topical tramadol was not FDA approved. The approved form of tramadol is for oral consumption, which is not recommended as first line therapy. Gabapentin is not recommended as a topical analgesic as there is no peer reviewed literature to support use. The guidelines state any compounded agent that contains at least 1 drug or drug class that is not recommended is not recommended and gabapentin and tramadol are not recommended for topical application. Lidocaine is not recommended in any formulation other than a Lidoderm patch. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

**Extracorporeal Shock Wave Therapy (ESWT) of the Right Upper Extremity (Ortho Shockwave): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Extracorporeal Shock Wave Therapy.

**Decision rationale:** The request for extracorporeal shockwave therapy to the right upper extremity (ortho shockwave) is not medically necessary. The injured worker complains of right shoulder, elbow, and wrist pain. The Official Disability Guidelines recommend extracorporeal shockwave therapy for calcifying tendinitis but not for other shoulder disorders. For injured workers with calcifying tendinitis of the shoulder with inhomogenous deposits, quality evidence has found that extracorporeal shockwave therapy is equivalent to or better than surgery, and it may be given priority because of its noninvasiveness. The guideline's criteria for the use of extracorporeal shockwave therapy is injured workers whose pain from calcifying tendinitis of the shoulder has remained despite 6 months of standard treatment and at least 3 conservative treatments have been performed prior to the use of ESWT, such as rest, ice, NSAIDs, orthotics, physical therapy, and injections. The guidelines contraindicate ESWT for injured workers who had physical or occupational therapy within the past 4 weeks or injured workers who received a local steroid injection within the past 6 weeks, or in injured workers with bilateral pain or injured workers who have previous surgery for the condition. There was a lack of documentation with the diagnosis of calcifying tendinitis to warrant an extracorporeal shockwave therapy. Additionally, the request failed to provide the number of therapy sessions requested. Therefore, the request is not medically necessary.

**Tennis Elbow Support: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 28.

**Decision rationale:** The request for a tennis elbow support is not medically necessary. The injured worker was diagnosed with lateral epicondylitis in September 2013. The California

MTUS/ACOEM Practice Guidelines state that tennis elbow bands, braces, or epicondylitis straps are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence to support their use, they are recommended. The request failed to provide which elbow the tennis elbow band was to be utilized for. Therefore, the request is not medically necessary.

### **Magnetic Resonance Arthrography (MRA) of the Right 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, ELBOW CHAPTER

**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, Radiography.

**Decision rationale:** complains of right shoulder, elbow, wrist, and hand pain. The Official Disability Guidelines state when initial radiographs are equivocal or in the presence of certain clinical or radiographic findings, further imaging is appropriate. This may be as simple as an expanded series with special views for fluoroscopic spot films; or it may include tomography, arthrography, bone scintigraphy, computed tomography, or magnetic resonance imaging. For inflammatory arthritis, however, high- resolution in office MRI with average follow up of 8months detects changes in bony disease better than radiography, which is insensitive for detecting changes in bone origins for this injured worker population and timeframe. Although arthrography is still the reference for the diagnosis of intrinsic ligament and cartilaginous lesions, MRI can sometimes be sufficient. There is a lack of documentation with red flags or significant changes in clinical findings to warrant arthrography of the right elbow. Additionally, there is a lack of documentation regarding conservative treatments other than steroid injections or imaging to warrant an MRA. Therefore, the request is not medically necessary.

### **Magnetic Resonance Arthrography (MRA) of the Right Wrist: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, WRIST AND HAND CHAPTER

**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, Radiography.

**Decision rationale:** The request for an MRA of the right wrist is not medically necessary. The injured worker complains of right shoulder, elbow, wrist, and hand pain. The Official Disability Guidelines state when initial radiographs are equivocal or in the presence of certain clinical or radiographic findings, further imaging is appropriate. This may be as simple as an expanded series with special views for fluoroscopic spot films; or it may include tomography, arthrography, bone scintigraphy, computed tomography, or magnetic resonance imaging. For inflammatory arthritis, however, high- resolution in office MRI with The request for an MRA of

the right wrist is not medically necessary. The injured worker average follow up of 8months detects changes in bony disease better than radiography, which is insensitive for detecting changes in bone origins for this injured worker population and timeframe. Although arthrography is still the reference for the diagnosis of intrinsic ligament and cartilaginous lesions, MRI can sometimes be sufficient. There is a lack of documentation with red flags or significant changes in clinical findings to warrant arthrography of the right elbow. Additionally, there is a lack of documentation regarding conservative treatments other than steroid injections or imaging to warrant an MRA. Therefore, the request is not medically necessary.

### **Magnetic Resonance Arthrography (MRA) of the Right Hand: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, WRIST AND HAND CHAPTER

**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, Radiography.

**Decision rationale:** The request for an MRA of the right hand is not medically necessary. The injured worker complains of right shoulder, elbow, wrist, and hand pain. The Official Disability Guidelines state when initial radiographs are equivocal or in the presence of certain clinical or radiographic findings, further imaging is appropriate. This may be as simple as an expanded series with special views for fluoroscopic spot films; or it may include tomography, arthrography, bone scintigraphy, computed tomography, or magnetic resonance imaging. For inflammatory arthritis, however, high- resolution in office MRI with The request for an MRA of the right wrist is not medically necessary. The injured worker average follow up of 8months detects changes in bony disease better than radiography, which is insensitive for detecting changes in bone origins for this injured worker population and timeframe. Although arthrography is still the reference for the diagnosis of intrinsic ligament and cartilaginous lesions, MRI can sometimes be sufficient. There is a lack of documentation with red flags or significant changes in clinical findings to warrant arthrography of the right elbow. Additionally, there is a lack of documentation regarding conservative treatments other than steroid injections or imaging to warrant an MRA. Therefore, the request is not medically necessary.

### **Cyclobenzaprine (2%), Tramadol (10%), and Flurbiprofen (20%): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen, page 72, Topical analgesics page 111, Cyclobenzaprine page 41, Tramadol Page(s): 7.

**Decision rationale:** The request for cyclobenzaprine (2%), tramadol (10%), and flurbiprofen (20%) is not medically necessary. The California Chronic Pain Medical Treatment Guidelines

indicate topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. The guidelines primarily recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2 week period. Flurbiprofen is classified as a nonsteroidal anti-inflammatory agent. This agent is currently not FDA approved for topical application. FDA approved routes of administration for flurbiprofen include oral tablets or ophthalmologic solution. The guidelines do not recommend tramadol as a topical application. The approved form of tramadol is for oral consumption, which is not recommended as first line therapy. The guidelines do not recommend the topical use of cyclobenzaprine as a topical muscle relaxant as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine to other agents is not recommended. The guidelines do not recommend cyclobenzaprine, tramadol, or flurbiprofen for topical analgesia. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.