

<b>Case Number:</b>	CM14-0081578		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	12/05/2011
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	05/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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 Orthopedic Surgery and is licensed to practice in Texas. 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 44-year-old male who reported an injury on 12/05/2011 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to the back, bilateral shoulders and arms, bilateral wrists, and developed headaches, breathing, and sleeping issues with symptoms of depression and stress. The injured worker was evaluated on 05/07/2014. It was noted that the injured worker had complaints of the lumbar spine, bilateral upper extremities. Objective findings included tenderness to palpation of the frontal area, tenderness to of the bilateral paraspinal musculature with trigger points identified, decreased range of motion with a positive right sided straight leg raising test. Evaluation of the left shoulder documented tenderness to palpation of the anterior and posterior joint with restricted range of motion and a positive Neer's test, evaluation of the right shoulder documented tenderness to palpation of the anterior and posterior joint with a positive impingement sign. Evaluation of the elbows documented bilateral tenderness to palpation of the joint with positive Cozen's/Mill's/Tinel's signs. Evaluation of the bilateral wrists documented tenderness to palpation of the bilateral wrists with positive Tinel's and decreased deep tendon reflexes. The injured worker's diagnoses included lumbosacral musculoligamentous sprain/strain with radiculitis, bilateral shoulder sprain/strain, bilateral shoulder tendonitis, bilateral elbow sprain/strain, bilateral elbow lateral epicondylitis, bilateral elbow medial epicondylitis, left wrist sprain/strain, possible carpal tunnel syndrome, and bilateral chronic wrist pain due to overuse. The injured worker's treatment plan included FluriFlex 120 gm, TGHOT 120 gm, a hot and cold therapy unit, a urine drug screen, an MRI of the bilateral shoulders, a Functional Capacity Evaluation, and shockwave therapy for the left shoulder. A request for authorization form was submitted to support the request.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**FluriFlex 180gm:** 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 Opioids Page(s): 111.

**Decision rationale:** The requested FluriFlex 180gm is not medically necessary or appropriate. The requested medication is a compounded topical medication and contains Flurbiprofen and Cyclobenzaprine. The California Medical Treatment Utilization Schedule does not support the use of topical non-steroidal anti-inflammatory drugs unless there is documentation that the injured worker is unable to tolerate non-steroidal anti-inflammatory drugs and requires topical application. Furthermore, the California Medical Treatment Utilization Schedule do not support the use of Cyclobenzaprine in a topical formulation as there is little scientific evidence to support the efficacy and safety of this medication in a topical formulation. Furthermore, the request as it is submitted does not clearly identify frequency of treatment or an applicable body part. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested FluriFlex 180 gm is not medically necessary or appropriate.

**TG Hot 180gm:** 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 Page(s): 111. Decision based on Non-MTUS Citation Effectiveness of topical administration of opioids in palliative care: a systematic review; B LeBon, G Zeppetella, IJ Higginson - Journal of pain and symptoms,2009 - Elsevier.

**Decision rationale:** The requested TG Hot 180 gm is not medically necessary or appropriate. The requested medication is a compounded topical formulation that contains Tramadol, Gabapentin, Menthol, Camphor, and Capsaicin. The California Medical Treatment Utilization Schedule does not support the use of Gabapentin in a topical formulation as there is little scientific evidence to support the efficacy and safety of this medication. The California Medical Treatment Utilization Schedule does not support the use of Capsaicin unless there is documentation that the injured worker has failed first line chronic pain management treatments. The clinical documentation does not provide any evidence that the injured worker has failed to respond to first line medications to include antidepressants and anticonvulsants. The California Medical Treatment Utilization Schedule and Official Disability Guidelines do not address opioids as a topical agent. Peer reviewed literature does not support the use of tramadol as a topical analgesic as there is little scientific evidence to support the efficacy and safety of this medication in a topical formulation. Furthermore, the request as it is submitted does not clearly

define a frequency of treatment or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested TG Hot 180gm is not medically necessary or appropriate.

**Urine Toxicology/Drug Screen: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Pain Procedure Summary (UDT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

**Decision rationale:** The requested Urine Toxicology/Drug Screen is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend drug testing for injured workers who are at risk for aberrant behavior and using opioids for chronic pain management. The clinical documentation submitted for review does not provide any evidence that the injured worker is taking opioids and requires regular urine drug tests for monitoring for aberrant behavior. The clinical documentation submitted for review does not provide any evidence of overuse or withdrawal from any type of illicit street drugs that would require the need for a urine drug screen. As such, the requested Urine Toxicology/Drug Screen is not medically necessary or appropriate.

**MRI Scan of the bilateral shoulders: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 202. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Shoulder Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** The requested MRI scan of the bilateral shoulders is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends imaging studies for shoulder injuries when it is documented that the injured worker has undergone a non-diagnostic x-ray and has failed to respond to conservative treatment. The clinical documentation fails to identify any specific conservative treatment that has been directed towards the bilateral shoulders. Furthermore, there is no documentation that the patient has undergone an x-ray that failed to identify any abnormalities. As such, the requested MRI scan of the bilateral shoulders is not medically necessary or appropriate.

**Extracorporeal Shock Wave Therapy (ECSWT): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Shoulder Procedure Summary (ECSWT).

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

**Decision rationale:** The requested Extracorporeal Shock Wave Therapy (ECSWT) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this type of therapy. Official Disability Guidelines do not support the use of extracorporeal shockwave therapy as it is considered investigational and not supported by significant scientific studies. Official Disability Guidelines address extra corporeal shockwave therapy in the elbow, ankle and foot, and shoulder chapters. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not specifically identify an applicable body part or duration of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested extra corporeal shockwave therapy is not medically necessary or appropriate.

**Physical Performance-Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Fitness for Duty Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** The requested physical Performance-Functional Capacity Evaluation is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends a Functional Capacity Evaluation when a more precise delineation of an injured worker's functional capabilities is required to determine the injured worker's work capabilities. There is no indication within the clinical documentation that this cannot be determined by a traditional physical examination. There is no documentation that the injured worker has had any failed return to work attempts or has reached maximum medical improvement. As such, the requested physical Performance-Functional Capacity Evaluation is not medically necessary or appropriate.

**Physical Therapy Evaluation and Treatment for the Lumbar Spine, Bilateral Shoulders, Elbows and Wrists 2 times a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Low Back, Elbow, Forearm, Wrist & Hand & Shoulder Procedure Summary.

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

**Decision rationale:** The requested Physical Therapy Evaluation and Treatment for the Lumbar Spine, Bilateral Shoulders, Elbows and Wrists 2 times a week for 6 weeks is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends up to 10 visits for myofascial, radicular, and neuropathic pain. The request exceeds this recommendation. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested Physical Therapy Evaluation and Treatment for the Lumbar Spine, Bilateral Shoulders, Elbows and Wrists 2 times a week for 6 weeks is not medically necessary or appropriate.