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| Case Number: | CM14-0161130 | | |
| Date Assigned: | 10/06/2014 | Date of Injury: | 08/30/2010 |
| Decision Date: | 01/30/2015 | UR Denial Date: | 08/19/2014 |
| Priority: | Standard | Application Received: | 10/01/2014 |

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 Rehab, has a subspecialty in Interventional spine 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:

The patient is a 67 year old male with an injury date of 08/30/10. Based on the 07/21/14 progress report, the patient complains of pain in the right shoulder and arm rated 2/10. Physical examination to the right shoulder revealed grade 3 tenderness to palpation. Positive Impingement and Supraspinatus tests. Patient reports that physical therapy helps decrease pain, tenderness and spasm, and indicates that his functions and activities of daily living have improved. Topical medications were prescribed "to minimize possible neurovascular complications; and to avoid complications associated with the use of narcotic medications, as well as GI bleeding from the use of NSAID's medications." Patient is temporarily totally disabled. Diagnosis 07/21/14 - Right shoulder strain/sprain- Right shoulder tendinosis- Rule out right shoulder impingement syndrome- Right shoulder adhesive capsulitis- Right shoulder rotator cuff tear tendinosis The utilization review determination being challenged is dated 08/19/14. The rationale follows: 1) Amitriptyline 10%/ Dextromorphan 10%/ and Gabapentin 10% in cream base: "...have not been shown to be effective. No studies are shown for effectiveness for shoulder tendonitis." 2) EXTRACORPOREAL SHOCKWAVE THERAPY TO RIGHT SHOULDER: "ESWT to the right shoulder is of questionable value for treatment of impingement syndrome is not supported..." Treatment report dated 07/21/14 was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline 10%/Dextromethorphan 10%/ Gabapentin 10% in cream base 210 gm:
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 creams Page(s): 111.

Decision rationale: The patient presents with pain in the right shoulder and arm rated 2/10. The request is for Amitriptyline 10%/ Dextromorphan 10%/ and Gabapentin 10% in cream base 210 gm. Patient's diagnosis on 07/21/14 included right shoulder strain/sprain, rotator cuff tear tendinosis, and adhesive capsulitis. Physical examination to the right shoulder revealed grade 3 tenderness to palpation. Positive Impingement and Supraspinatus tests. Patient reports that physical therapy helps decrease pain, tenderness and spasm, and indicates that his functions and activities of daily living have improved. Patient is temporarily totally disabled. The MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Gabapentin: Not recommended. Baclofen: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." Per progress report dated 07/21/14, topical medications were prescribed "to minimize possible neurovascular complications; and to avoid complications associated with the use of narcotic medications, as well as GI bleeding from the use of NSAID's medications." However, MTUS page 111 states that if one of the compounded topical product is not recommended, then the entire product is not. In this case, the requested topical compound contains Gabapentin, which is not supported for topical use in lotion form per MTUS. Therefore the request is not medically necessary.

Extracorporeal Shock Wave Therapy (ECSWT) to right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), extracorporeal shockwave therapy

Decision rationale: The patient presents with pain in the right shoulder and arm rated 2/10. The request is for extracorporeal shockwave therapy to right shoulder. Patient's diagnosis on 07/21/14 included right shoulder strain/sprain, rotator cuff tear tendinosis, and adhesive capsulitis. Physical examination to the right shoulder revealed grade 3 tenderness to palpation. Positive Impingement and Supraspinatus tests. Patient reports that physical therapy helps decrease pain, tenderness and

spasm, and indicates that his functions and activities of daily living have improved. Patient is temporarily totally disabled. ODG Guidelines, Shoulder (Acute & Chronic), extracorporeal shockwave therapy (ESWT) states: "ESWT for shoulder problems: Criteria for the use of Extracorporeal Shock Wave Therapy (ESWT): 1) Patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. 2) At least three conservative treatments have been performed prior to use of ESWT. These would include: a. Rest, b. Ice, c. NSAIDs, d. Orthotics, e. Physical Therapy, e. Injections (Cortisone). 3) Contraindicated in Pregnant women; Patients younger than 18 years of age; Patients with blood clotting diseases, infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage; Patients with cardiac pacemakers; Patients who had physical or occupational therapy within the past 4 weeks; Patients who received a local steroid injection within the past 6 weeks; Patients with bilateral pain; Patients who had previous surgery for the condition. 4) Maximum of 3 therapy sessions over 3 weeks." Treater has not provided reason for the request. Patient reports that physical therapy helps, but treatment history is not provided. There is no list of medications other than prescribed topicals, and no discussion of prior conservative treatments, as required by guidelines. Patient has a diagnosis of rotator cuff tear tendinosis, but there is no mention of calcific tendinitis for which extracorporeal shockwave therapy would be indicated. Furthermore, treater has not indicated number of sessions in the request. Therefore the request is not medically necessary.