

Case Number:	CM15-0109557		
Date Assigned:	06/16/2015	Date of Injury:	08/11/2014
Decision Date:	09/01/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/08/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 59-year-old female who sustained an industrial injury on 08/11/2014. Current diagnoses include lumbar sprain/strain, right knee medial cartilage, right elbow pain, and lumbar disc displacement. Previous treatments included medications, epidural steroid injection, shockwave therapy, and physical therapy. Previous diagnostic studies include MRI's. Report dated 05/12/2015 noted that the injured worker presented for follow up of lumbar spine, right knee, and right elbow complaints. It was noted that the epidural steroid injection provided only modest results. Pain level was not included. Physical examination was positive for decreased range of motion in the lumbar spine with spasm and tenderness, and right knee and right elbow tenderness. The treatment plan included requests topical medication, chiropractic treatment, urinalysis, shockwave treatment, and follow up in 4 weeks. Disputed treatments include ortho shockwave to right knee, urine toxicology screening, topical compounds; Flurbiprofen 10%, Capasaicin 0.025%, Camphor 2%, #120mg & ketoprofen 10%, Cyclobenzaprine 3%, Lidocaine 5%, follow up appointment and chiropractic treatment 2 x 4 to lumbar.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ortho shockwave to right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 940.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg chapter, under extracorporeal shock wave therapy.

Decision rationale: Based on the 06/10/15 progress report provided by treating physician, the patient presents with pain to right knee. The request is for ORTHO SHOCKWAVE TO RIGHT KNEE. Patient's diagnosis per Request for Authorization form dated 05/12/15 includes right knee medial cartilage tear, lumbar disc displacement and lumbar sprain/strain. Physical examination to the right knee on 06/10/15 revealed tenderness to joint and laxity. Treatment to date has included imaging studies, epidural steroid injection, shockwave therapy, physical therapy and medications. Patient's medications include topical compound creams, Theramine, Gabadone, Sentra AM and Sentra PM, per 11/25/14 report. The patient is off work, per 06/10/15 report. ODG Knee & Leg chapter, under extracorporeal shock wave therapy has the following: "Under study for patellar tendinopathy and for long-bone hypertrophic nonunions. In the first study of this therapy for management of chronic patellar tendinopathy, extracorporeal shockwave therapy seemed to be safer and more effective, with lower recurrence rates, than conventional conservative treatments, according to results of a recent small, randomized controlled trial. New research suggests that extracorporeal shock-wave therapy (ESWT) is a viable alternative to surgery for long-bone hypertrophic nonunions. However, the findings need to be verified, and different treatment protocols as well as treatment parameters should be investigated, including the number of shock waves used, the energy levels applied and the frequency of application. New data presented at the American College of Sports Medicine Meeting suggest that extracorporeal shockwave therapy (ESWT) is ineffective for treating patellar tendinopathy, compared to the current standard of care emphasizing multimodal physical therapy focused on muscle retraining, joint mobilization, and patellar taping." Treater has not discussed this request. Diagnosis on 06/10/15 included right knee internal knee derangement and patient continues with pain to the right knee. It appears patient has been attending shockwave therapy based on 4 ESWT reports dated 12/18/14 - 06/03/15 which were provided. However, there is no guideline support for Shockwave Therapy to the knee, as the procedure is still under study. Furthermore, treater has not indicated number of sessions in the request. This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.

Urine toxicology screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug screening.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid management Drug testing Page(s): 77, 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter under Urine Drug Testing.

Decision rationale: Based on the 06/10/15 progress report provided by treating physician, the patient presents with pain to right knee and low back. The request is for URINE TOXICOLOGY

SCREEN. Patient's diagnosis per Request for Authorization form dated 05/12/15 includes right knee medial cartilage tear, lumbar disc displacement and lumbar sprain/strain. Physical examination to the right knee on 06/10/15 revealed tenderness to joint and laxity. Treatment to date has included imaging studies, epidural steroid injection, shockwave therapy, physical therapy and medications. Patient's medications include topical compound creams, Theramine, Gabadone, Sentra AM and Sentra PM, per 11/25/14 report. The patient is off work, per 06/10/15 report. MTUS Chronic Pain Medical Treatment Guidelines, under Drug Testing, pg 43 states: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. ODG-TWC Guidelines, online, Pain chapter for Urine Drug Testing states: "Patients at 'low risk' of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders." Treater has not discussed this request. Urine test for toxicology have been ordered, per progress reports dated 12/12/14, 02/06/15, and 06/10/15. MTUS does not specifically discuss the frequency that urine drug screens should be performed. However, ODG is more specific on the topic and recommends urine drug screens on a yearly basis if the patient is at low risk. In this case, while guidelines do support urine drug screening, treater has not provided patient's risk profile, nor indicated "high risk" of adverse outcomes, or that patient has an active substance abuse disorder. Furthermore, there are no opioid medications in provided medical records. This request is not in accordance with guidelines and cannot be warranted given lack of documentation. Therefore, the request IS NOT medically necessary.

Topical compounds; Flurbiprofen 10%, Capasaicin 0.025%, Camphor 2%, #120mg & ketoprofen 10%, Cyclobenzarprine 3%,Lidocaine 5% #120mg: 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, 112.

Decision rationale: Based on the 06/10/15 progress report provided by treating physician, the patient presents with pain to right knee and low back. The request is for TOPICAL COMPOUNDS; FLURBIPROFEN 10%, CAPASAICIN 0.025%, CAMPHOR 2%, #120MG & KETOPROFEN 10%, CYCLOBENZAPRINE. Patient's diagnosis per Request for Authorization form dated 05/12/15 includes right knee medial cartilage tear, lumbar disc displacement and lumbar sprain/strain. Physical examination to the right knee on 06/10/15 revealed tenderness to joint and laxity. Treatment to date has included imaging studies, epidural steroid injection, shockwave therapy, physical therapy and medications. Patient's medications include topical compound creams, Theramine, Gabadone, Sentra AM and Sentra PM, per 11/25/14 report. The patient is off work, per 06/10/15 report. MTUS Topical Analgesics guidelines pages 111 and 112 has the following regarding topical creams, "There is little to no

research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS further states, "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis. Baclofen: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." Treater has not provided reason for the request, nor indicate area to be treated. In this case, the requested topical compound contains Ketoprofen and Cyclobenzaprine, which are not currently FDA approved for topical application, per MTUS. MTUS page 111 states that if one of the compounded topical products is not recommended, then the entire product is not. This request does not meet guideline criteria. Therefore, the request IS NOT medically necessary.

Chiropractic treatment 2 times a week for 4 weeks lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: Based on the 06/10/15 progress report provided by treating physician, the patient presents with low back pain. The request is for **CHIROPRACTIC TREATMENT 2 TIMES A WEEK FOR 4 WEEKS LUMBAR**. Patient's diagnosis per Request for Authorization form dated 05/12/15 includes right knee medial cartilage tear, lumbar disc displacement and lumbar sprain/strain. Physical examination to the right knee on 06/10/15 revealed tenderness to joint and laxity. Treatment to date has included imaging studies, epidural steroid injection, shockwave therapy, physical therapy and medications. Patient's medications include topical compound creams, Theramine, Gabadone, Sentra AM and Sentra PM, per 11/25/14 report. The patient is off work, per 06/10/15 report. MTUS Guidelines, pages 58-59, **CHRONIC PAIN MEDICAL TREATMENT GUIDELINES: Manual therapy & manipulation** recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. MTUS page 8 also requires that the treater monitor the treatment progress to determine appropriate course of treatments. Treater has not discussed the request. Given patient's continued symptoms and diagnosis, a short course of chiropractic would be indicated by guidelines. However, per UR referral form dated 05/15/15, the patient has 12 authorized chiropractic visits. In this case, treater has not provided a precise treatment history nor indicated efficacy of prior therapy. There is no indication of new injury or flare ups/recurrences to warrant additional treatment, either. Furthermore, additional 8 visits would exceed what is allowed by guidelines. Therefore, the request IS NOT medically necessary.