

Case Number:	CM15-0135605		
Date Assigned:	08/21/2015	Date of Injury:	10/30/2014
Decision Date:	10/02/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/14/2015

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: New York
 Certification(s)/Specialty: Internal Medicine

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 38 year old male who sustained an industrial injury on 10-30-2014. Current diagnoses included lumbar disc protrusion, lumbar radiculopathy, lumbar spondylosis, lumbar sprain-strain, sprain sacroiliac joint-left, lumbar spine pars defects bilaterally, right shoulder labral tear, right shoulder bursitis, and right shoulder impingement syndrome. Previous treatments included medications, surgical intervention, physical therapy, extracorporeal shockwave therapy. Previous diagnostic studies included urine drug screening and MRI's. Initial injuries occurred when the worker was pulling a hose of cement and felt a pull when lifting. Report dated 05-14-2015 noted that the injured worker presented with complaints that included lumbar spine pain and right shoulder pain. Physical examination was positive for decreased lumbar spine range of motion, tenderness in the left sacroiliac joint and lumbar paravertebral muscles, muscle spasm of the lumbar paravertebral muscles, straight leg raise is positive on the left, Patrick's and Fabere's is positive on the left, right shoulder range of motion is decreased, tenderness of the acromioclavicular joint, anterior shoulder, lateral shoulder and posterior shoulder, muscle spasm of the anterior shoulder and posterior shoulder, Neer's is positive, and Hawkin's is positive. The treatment plan included a request for right shoulder arthroscopic subacromial decompression and debridement of labrum tears, request 12 visits of post op therapy, pending EMG-NCV bilateral lower extremities, prescribed Norco, request for additional physical therapy, and prescribed compound medications for general joint & musculoskeletal pain and neuropathic pain. Currently the injured is not working. Disputed treatments include associated surgical services-6 extracorporeal shockwave therapy for the lumbar spine, associated

surgical service-unknown trigger points impedance imaging, associated surgical service-unknown localized intense neurostimulation therapy, HNPC1-amitriptyline NCL 10% gabapentin 10% bupivacaine HCL 5% Hyaluronic acid 0.2% in cream base, and HMPHCC2- Flurbiprofen 20% Baclofen 5% camphor 2% menthol 2% dexamethasone micro 0.2% Capsaicin 0.025% Hyaluronic acid 0.2% in cream base

IMR ISSUES, DECISIONS AND RATIONALES

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

HMPHCC2- Flurbiprofen 20%/ Baclofen 5%/ Camphor 2%/ Menthol 2%/ Dexamethasone Micro 0.2%/ Capsaicin 0.025%/ Hyaluronic Acid 0.2% in cream base: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Capsaicin, topical. Decision based on Non-MTUS Citation Haimovic IC, Beresford HR, Dexamethasone is not superior to placebo for treating lumbosacral radicular pain. Neurology. 1986; 36:1593-4.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Topical analgesics Page(s): 27-28 and 111-113.

Decision rationale: According to the MTUS chronic pain medical treatment guidelines, "topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. If any compounded product contains at least one drug or drug class that is not recommended, the compounded product is not recommended." Flurbiprofen, used as a topical NSAID, has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Baclofen can be used as a muscle relaxant, and is not recommended as a topical analgesic. Capsaicin is recommended as an option in patients who have not responded or are intolerant to other treatments. Because at least one drug or drug class is not recommended, the compound medication is not medically necessary. Also, even though the treating physician stated that the medication was for general joint and musculoskeletal pain the request did not include the quantity, and site of application. As such, the prescription is not sufficient and not medically necessary. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Therefore the request for HMPHCC2- Flurbiprofen 20% Baclofen 5% Camphor 2% Menthol 2% Dexamethasone Micro 0.2% Capsaicin 0.025% Hyaluronic Acid 0.2% in cream base is not medically necessary and appropriate.

Associated surgical service: 6 extracorporeal shockwave therapy for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic): Shock wave therapy (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Chapter, Low Back Chapter--Extracorporeal shock wave therapy (ESWT).

Decision rationale: ODG states Extracorporeal Shock Wave Therapy (ESWT) is not recommended for back pain. The available evidence does not support the effectiveness of shock wave for treating back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. Two small studies have been published for upper back or neck pain. In this study trigger point treatment with radial shock wave used in combination with physical therapy provided temporary relief of neck and shoulder pains, but the effects of radial shock wave without physical therapy need to be examined in further studies. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of guidelines, the medical necessity for extracorporeal shockwave therapy for the lumbar spine is not medically necessary.

Associated surgical service: Unknown trigger points impedance imaging: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic): Trigger point impedance imaging (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter--Hyperstimulation analgesia.

Decision rationale: As per Official Disability Guidelines (ODG) Trigger point impedance imaging/localized intense neuro-stimulation therapy is not recommended until there are higher quality studies. Initial results are promising, but only from two low quality studies sponsored by the manufacturer (Nervomatrix Ltd., Netanya, Israel). Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings (A fibers), thus causing the release of endogenous endorphins. This procedure, usually described as hyperstimulation analgesia, has been investigated in several controlled studies. However, such treatments are time consuming and cumbersome, and require previous knowledge of the localization of peripheral nerve endings responsible for LBP or manual impedance mapping of the back, and these limitations prevent their extensive utilization. In this case, there is no compelling evidence presented by the treating provider that indicates the need for this therapy in this injured worker. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of guidelines, the medical necessity for trigger point impedance imaging is not medically necessary.

Associated surgical service: Unknown localized intense neurostimulation therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic): Hyperstimulation analgesia (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter--Hyperstimulation analgesia.

Decision rationale: As per Official Disability Guidelines (ODG) localized intense neuro-stimulation therapy is not recommended until there are higher quality studies. Initial results are promising, but only from two low quality studies sponsored by the manufacturer (Nervomatrix Ltd., Netanya, Israel). Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings (A fibers), thus causing the release of endogenous endorphins. This procedure, usually described as hyperstimulation analgesia, has been investigated in several controlled studies. However, such treatments are time consuming and cumbersome, and require previous knowledge of the localization of peripheral nerve endings responsible for LBP or manual impedance mapping of the back, and these limitations prevent their extensive utilization. In this case, there is no compelling evidence presented by the treating provider that indicates the need for this therapy in this injured worker. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of guidelines, the medical necessity for localized intense neuro-stimulation therapy is not medically necessary.

HNPC1-Amitriptyline NCL 10%/Gabapentin 10%/Bupivacaine HCL 5%/Hyaluronic Acid 0.2% in cream base: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: According to the MTUS chronic pain medical treatment guidelines, "topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. If any compounded product contains at least one drug or drug class that is not recommended, the compounded product is not recommended." Gabapentin are not FDA approved for a topical application. There is no peer-reviewed literature to support use. Because at least one drug or drug class is not recommended, the compound medication is not medically necessary. Also, even though the treating physician stated that the medication was for neuropathic pain the request did not include the quantity, and site of application. As such, the prescription is not sufficient and not medically necessary. MTUS states that gabapentin is not recommended topically. There is no peer-reviewed literature to support use. Therefore the request for HNPC1-amitriptyline NCL 10% gabapentin 10% bupivacaine HCL 5% hyaluronic acid 0.2% in cream base is not medically necessary and appropriate.