

<b>Case Number:</b>	CM15-0198013		
<b>Date Assigned:</b>	10/16/2015	<b>Date of Injury:</b>	03/20/2014
<b>Decision Date:</b>	12/01/2015	<b>UR Denial Date:</b>	09/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 27-year-old female, who sustained an industrial injury on March 20, 2014. She reported injury to her lower back and right leg. The injured worker was diagnosed as having lumbar spine muscular ligamentous sprain and strain with radiculitis, bilateral hip sprain and strain versus lumbar radiculitis, bilateral knee sprain and strain versus lumbar radiculitis, bilateral ankle sprain and strain and bilateral foot plantar fasciitis. Treatment to date has included diagnostic studies, chiropractic treatment, extracorporeal shockwave treatment, injections, physical therapy and medication. On July 22, 2015, the injured worker complained of lower back, bilateral hips, bilateral knees and bilateral ankles-feet pain. The lower back pain was rated as a 4-5 on a 1-10 pain scale. The right hip, knee and bilateral ankles-feet pain were rated as a 5 on the pain scale. Overall, the pain was noted to be decreased from a prior exam visit. Left hip pain was rated as a 5 on the pain scale, which was the same from a prior visit. Left knee pain was rated as a 5 on the pain scale, which was noted to be increased from a prior exam visit. The treatment plan included continuation of chiropractic therapy, Tramadol, Theramine and topical cream. On September 14, 2015, utilization review denied a request for continuation of physical therapy of the lumbar spine and bilateral lower extremities two times a week for six weeks, Flurifex 180 grams (PM), TGHOT 180 grams (AM), compression stocking, MRI of the left knee, extracorporeal shock wave therapy and EMG-NCV bilateral lower extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continuation of physical therapy (PT) of the lumbar spine and bilateral lower extremities 2 times a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient has ongoing PT visits since her injury in 03/20/14. There is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the additional 12 PT (2x6) sessions requested, which exceed the MTUS and ODG guidelines. Medical necessity for the additional PT visits requested has not been established. The requested services are not medically necessary.

**Fluriflex 180grams (PM): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the topical analgesic compound is Fluriflex, which contains Flurbiprofen and Cyclobenzaprine. There is no documentation of intolerance to other previous oral medications. The MTUS guidelines state that Flurbiprofen, lidocaine, capsaicin and/or muscle relaxants (Cyclobenzaprine, in this case) are not

recommended for topical applications. Therefore, medical necessity for this topical analgesic compound has not been established. The request for Fluriflex is not medically necessary.

**TGHOT 180 grams (AM): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic compound is TGHOT cream, which contains Tramadol 8%, gabapentin 10%, menthol 2%, camphor 2%, and capsaicin 0.05%. Gabapentin is not recommended as a topical agent per CA MTUS Guidelines. There is no peer-reviewed literature to support its use. Tramadol is not recommended as a first line therapy. Capsaicin is recommended only as an option in patients who have not responded to or are intolerant to other treatments. Since the guidelines do not recommend several of the ingredients, there is no medical necessity for this compound. Additionally, the documentation submitted for review does not provide evidence of the necessity for 2 topical analgesics. The request for TGHOT 180 gm is not medically necessary or appropriate.

**Compression stocking: 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), Knee & Leg Chapter (Compression Garments).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Medscape Internal Medicine (2014).

**Decision rationale:** Good evidence for the use of compression is available, but little is known about dosimetry in compression, for how long and at what level compression should be applied. Low levels of compression 10-30 mmHg applied by stockings are effective in the management of telangiectases after sclerotherapy, varicose veins in pregnancy, the prevention of edema and deep vein thrombosis (DVT). High levels of compression produced by bandaging and strong compression stockings (30-40 mmHg) are effective at healing leg ulcers and preventing progression of post-thrombotic syndrome as well as in the management of lymphedema. There

is inconsistent evidence for compression stockings to prevent post-thrombotic syndrome (PTS) after first-time proximal deep venous thrombosis (DVT). In this case, there is no specific indication for a compression stocking. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

**MRI of the left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter: MRI's (magnetic resonance imaging).

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MRI, Knee.

**Decision rationale:** According to the ODG, indications for imaging of the knee include, acute trauma to the knee and non-traumatic knee pain. MRI best evaluates soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption). MRI scans are accurate to diagnose meniscus tears, but MRI is a poor predictor of whether or not the tear can be repaired. Studies showed that MRI studies are necessary if they are indicated by history and/or physical examination to assess for meniscal, ligamentous, or osteochondral injury or osteonecrosis, or if the patient had an unexpected finding that affected treatment. In this case, there is no evidence of internal derangement of the left knee on exam. Medical necessity for the requested MRI of the left knee has not been established. The requested study is not medically necessary.

**Extracorporeal Shock Wave Therapy (ESWT):** 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), Ankle & Foot Chapter: Extracorporeal shock wave therapy (ESWT).

**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, ESWT.

**Decision rationale:** According to the medical records, it is not clear if shockwave therapy sessions are being requested for this case. Extracorporeal shock wave therapy (ESWT) is a noninvasive treatment proposed to treat refractory tendonopathies such as, plantar fasciitis. It has also been introduced as an alternative to surgery for patients that have not responded to other conservative therapies. ESWT involves delivery of low or high-energy shock waves via a device to a specific site within the body. These pressure waves travel through fluid and soft tissue; their effects occur at sites where there is a change in impedance, such as the bone/soft tissue interface. Low-energy shock wave treatments are generally given in one session and usually require some type of anesthesia. According to the ODG, ESWT is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating foot pain. There are limited large-scale, long-term references showing the safety and efficacy of the requested

treatment in this patient's clinical scenario. Medical necessity for the requested procedure has not been established. The requested service is not medically necessary.

**EMG/NCV bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter: EMGs (electromyography) and Nerve Conduction Studies (NCS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) EMGs/NCVs.

**Decision rationale:** The request for diagnostic test EMG/NCV for bilateral upper lower is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm problems, or both, lasting more than 3 to 4 weeks. The ODG further states that nerve conduction studies are recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms based on radiculopathy. In this case, there is clear documentation of radiculopathy. Medical necessity for the requested studies has not been established. The requested studies are not medically necessary.