

Case Number:	CM15-0217219		
Date Assigned:	11/09/2015	Date of Injury:	01/07/2013
Decision Date:	12/24/2015	UR Denial Date:	10/21/2015
Priority:	Standard	Application Received:	11/04/2015

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 36 year old male who sustained an industrial injury on 1-7-2013. A review of medical records indicates the injured worker is being treated for status post right wrist ganglion cyst removal x 2 with recurrent cyst and right wrist synovitis-tendonitis. Medical records dated 10-14-2015 noted pain and numbness in the right wrist rated 7 out of 10. Pain remained unchanged from the prior visit. Physical examination noted grade 2 tenderness to palpation which remained unchanged since his last visit. There was a small cystic mass over the dorsal aspect of the right wrist. Treatment has included Flurbi (Nap) cream since at least 5-27-2015. Utilization review form dated 10-21-2015 non-certified ESWT 1x4 right wrist and Flurbi (Nap) cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

ESWT 1 time a week for 4 weeks for the right wrist: 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)- Treatment in Workers' Compensation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow chapter, under Extracorporeal shockwave therapy.

Decision rationale: Based on the 10/14/15 progress report provided by the treating physician, this patient presents with increasing pain/numbness in the right wrist rated 7/10. The treater has asked for ESWT 1 TIME A WEEK FOR 4 WEEKS FOR THE RIGHT WRIST on 9/2/15. The patient's diagnoses per request for authorization dated 10/14/15 are s/p right wrist ganglion cyst removal x2 with recurrent cyst, right wrist synovitis/tendinosis. The patient is s/p unspecified sessions of physical therapy which have decreased his pain/tenderness per 9/2/15 report. The patient has a small cystic mass over the dorsal aspect of the right wrist per 10/14/15 report. The patient is to return to full/customary work duties as of requesting 10/14/15 report. ODG-TWC guidelines under the Forearm, Wrist and hand chapter provides no discussion regarding ESWT for the wrists. ODG-TWC, Elbow chapter, under Extracorporeal shockwave therapy (ESWT) has the following: "Not recommended. High energy ESWT is not supported, but low energy ESWT may show better outcomes without the need for anesthesia, but is still not recommended. Trials in this area have yielded conflicting results. The value, if any, of ESWT for lateral elbow pain, can presently be neither confirmed nor excluded. After other treatments have failed, some providers believe that shock-wave therapy may help some people with heel pain and tennis elbow. However, recent studies do not always support this, and ESWT cannot be recommended at this time for epicondylitis, although it has very few side effects." According to progress report dated 9/2/15, the patient presents with right wrist pain. Physical examination noted grade 2 tenderness to palpation of the right wrist which has remained the same since last visit and no changes in neurocirculatory exam per 9/2/15 report. No radiographs or imaging of the wrist were included in provided reports. The medical file provided for review includes no rationale for the requested ESWT for the shoulder and wrist. In this case, guidelines do not discuss ESWT for the wrists but do not recommend it for the elbow. The request does not meet guideline indications. Therefore, the request IS NOT medically necessary.

Flurbin (Nap) Cream - LA (Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5%)- 180gm:
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: Based on the 10/14/15 progress report provided by the treating physician, this patient presents with increasing pain/numbness in the right wrist rated 7/10. The treater has asked for FLURBIN (NAP) CREAM - LA (FLURBIPROFEN 20%, LIDOCAINE 5%, AMITRIPTYLINE 5%)-180GM on 10/14/15. The patient's diagnoses per request for authorization dated 10/14/15 are s/p right wrist ganglion cyst removal x2 with recurrent cyst, right wrist synovitis/tendinosis. The patient is s/p unspecified sessions of physical therapy which have decreased his pain/tenderness per 10/14/15 report. The patient has a small cystic mass over the dorsal aspect of the right wrist per 10/14/15 report. The patient is to return to full/customary

work duties as of requesting 10/14/15 report. MTUS guidelines, Topical Analgesics Section, under Lidocaine Indication states: "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." MTUS Guidelines, Topical Analgesics section, page 111 also state that "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In regard to the Flurbi-Nap cream, the requested cream is not supported by MTUS guidelines. Lidocaine is not supported by MTUS in any topical formulation other than patch form. Flurbiprofen is only recommended for peripheral joint arthritis and tendinitis. MTUS guidelines do not support anti-depressant medications in topical formulations, and specifically state that any topical compound which contains an unsupported ingredient is not indicated. Therefore, this request IS NOT medically necessary.