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| Case Number: | CM15-0030275 | | |
| Date Assigned: | 02/23/2015 | Date of Injury: | 11/26/2013 |
| Decision Date: | 04/08/2015 | UR Denial Date: | 02/02/2015 |
| Priority: | Standard | Application Received: | 02/18/2015 |

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 Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 64 year old female, who sustained an industrial injury on 11/26/2013, after a fall. New onset hypertension was documented since 2/2014, reduced control of blood sugars, weight gain, and multiple strokes. The diagnoses have included headache. Treatment to date has included conservative measures. A magnetic resonance imaging of the lumbar spine report (flexion/extension), dated 2/09/2015, was submitted. Currently, the injured worker complains of headaches, neck pain, back pain, left shoulder/arm pain, left hip/thigh pain, and left knee pain. She also reported numbness in the left wrist/hand. Physical exam noted tenderness to palpation to the paraspinal muscles of the cervical, thoracic, and lumbar spines. Straight leg raise test was positive bilaterally. Tenderness was also noted to the left shoulder, arm, wrist, and hand. Tinel's sign and Phalen's test were positive. Tenderness was also noted to the left hip, thigh, and knee. She reported that function and activities of daily living were improved by 10% with physical therapy. The Utilization Review report indicated that the injured worker completed 12 physical therapy sessions. Incomplete physical therapy notes were submitted, if completed sessions were 12. Extracorporeal Shockwave Therapy reports for the left hip were submitted. Current medication regime was not noted. On 2/02/2015 Utilization Review non-certified a request for (4) Extracorporeal Shockwave Therapy sessions of the left wrist (weekly x4), citing ACOEM Guidelines, non-certified a request for 1 prescription for Flurbi(NAP) Cream-LA (Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5%) 180 gms, citing MTUS and Official Disability Guidelines, non-certified a request for 1 prescription for Gabacyclotram (Gabapentin 10%/Cyclobenzaprine 6%/Tramadol 10%) 180 gms, citing MTUS and Official Disability

Guidelines, modified a request for 12 Physical Therapy sessions for the cervical spine, thoracic spine, lumbar spine, left shoulder, left wrist, left hip, and left knee to 4 sessions, citing MTUS Chronic Pain Medical Treatment Guidelines, and non-certified a request for a single positional magnetic resonance imaging of the lumbar spine, citing ACOEM Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Four (4) Extracorporeal shockwave therapy sessions of the left wrist, once per week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 29.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 203, 29.

Decision rationale: According to MTUS guidelines, several studies evaluated the efficacy of Extracorporeal Shockwave Therapy for the treatment of lateral epicondylitis (LE). These studies did not demonstrate its benefit for the management LE. There are no studies supporting its use for neck, shoulder and wrist pain. There is a Some medium quality evidence supports manual physical therapy, ultrasound, and high energy extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. (MTUS Guidelines American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2007) Elbow Complaints; Extracorporeal Shockwave Therapy, page(s) 29 : Extracorporeal Shockwave Therapy. Twelve articles were reviewed, 10 studies 82,83,84,85,86,87,88,89,90,91 and two meta-analyses.62, 92. Of the 10 studies, two were of high quality, five of intermediate quality and three of low quality. One of the high-quality studies⁸² evaluated 60 subjects with symptoms for less than 1 year and more than 3 weeks, treating them with either active extracorporeal shockwave therapy (ESWT) with a simple stretching program (n = 31) or sham ESWT with a simple stretching program (n = 29). The authors concluded that "despite improvement in pain scores and pain-free maximum grip strength within groups, there does not appear to be a meaningful difference between treating lateral epicondylitis with extracorporeal shock wave therapy combined with forearm-stretching program and treating with forearm-stretching program alone, with respect to resolving pain within an 8-week period of commencing treatment." The second high-quality study evaluated 272 patients with at least 6 months of conservative treatment (135 received ESWT and 137 received placebo ESWT) and found that ESWT as "applied in the present study was ineffective in the treatment of lateral epicondylitis." ⁸⁵; One of the meta-analyses reviewed two studies, concluding "no added benefit of ESWT over that of placebo in the treatment of LE [lateral epicondylitis]." ⁶²; The other review analyzed nine studies (the studies reviewed above) and concluded that "when data were pooled, most benefits were not statistically significant. No difference for participants early or late in the course of condition." ⁹²; Quality studies are available on extracorporeal shockwave therapy in acute, subacute, and chronic lateral epicondylalgia patients and benefits have not been shown. This option is moderately costly, has some short-term side effects, and is not invasive. Thus, there is a recommendation against using extracorporeal shockwave therapy Evidence (A), Strongly Recommended. There is no

documentation of left shoulder tendinitis in this case and there is no justification for the use of this procedure for wrist pain. Therefore the prescription of Extracorporeal Shockwave Therapy (ESWT) 2 times a week for 6 weeks for Bilateral Wrist is not medically necessary.

**Prescription Flurbi(NAP) cream- LA (Flurbiprofen 20%/Lidocaine 5%/ Amitriptyline 5%)
180 gm: Upheld**

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen, Lidocaine, Amitriptyline.

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

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111) topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no evidence that Flurbiprofen as well as the other component of the proposed topical analgesic are effective in chronic pain management. Furthermore, there is no documentation of failure or intolerance of first line oral medications for the treatment of pain. Based on the above Flurbi (NAP) Cream-LA is not medically necessary.

**Prescription Gabacyclotram (Gabapentin 10%/ Cyclobenzaprine 6%/ Tramadol 10%)
180gm: Upheld**

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin, Cyclobenzaprine, Tramadol.

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

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Gabapentin is not recommended as a topical analgesic. Therefore, topical analgesic Compound: Gabacyclotram (Gabapentin 10%, Cyclobenzaprine 6%, Tramadol 10%) 180gm is not medically necessary.

Twelve (12) physical therapy sessions (2 times a week for 6 weeks) for the cervical/ thoracic and lumbar spine, left shoulder, left wrist, left hip and left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: According to MTUS guidelines, Physical Medicine is Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) There is no documentation of the efficacy and outcome of previous physical therapy sessions. The patient underwent 12 sessions of physical therapy without clear documentation of efficacy. There is no documentation that the patient cannot perform home exercise. Therefore, the request for 12 physical therapy sessions is not medically necessary.

One single positional MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: Regarding the indications for imaging in case of back pain, MTUS guidelines stated: "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on

the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)". Furthermore, and according to MTUS guidelines, MRI is the test of choice for patients considering back surgery, fracture or tumors that may require surgery. There is no indication that the patient would consider additional surgery as an option. In addition, the patient does not have any clear evidence of lumbar radiculopathy or any evidence of new findings. Therefore, the request for MRI of the lumbar spine is not medically necessary.