

Case Number:	CM15-0030776		
Date Assigned:	02/25/2015	Date of Injury:	01/04/2010
Decision Date:	04/09/2015	UR Denial Date:	02/09/2015
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: 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 54 year old male, who sustained a cumulative industrial injury from 2006 through November 1, 2010. He has reported low back pain and right shoulder pain. The diagnoses have included stroke, lumbar spine herniated disc and impingement syndrome of the right shoulder. Treatment to date has included radiographic imaging, diagnostic studies, conservative therapies, consultations, pain medications and work restrictions. Currently, the IW complains of low back pain and right shoulder pain. The injured worker reported an industrial injury from 2006 through November 1, 2010, resulting in the above described pain. It was noted he was treated conservatively without a resolution of pain. He started complaining of headache and was diagnosed with possible stroke in 2014. Evaluation on February 9, 2015, revealed continued complaints of pain. Medications and 2 shockwave therapies were ordered. On February 9, 2015, Utilization Review non-certified a request for requested 2 Orthopedic shockwave therapies, Cyclobenzaprine and Flurbiprofen 10%, Capsaicin 0.025%, Camphor 2% 120gm, Ketoprofen 10%, Cyclobenzaprine 3% and Lidocaine 5% 120gm, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On February 11, 2015, the injured worker submitted an application for IMR for review of requested 2 Orthopedic shockwave, Cyclobenzaprine and Flurbiprofen 10%, Capsaicin 0.025%, Camphor 2% 120gm, Ketoprofen 10%, Cyclobenzaprine 3% and Lidocaine 5% 120gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 Orthopedic shockwave: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 235. Decision based on Non-MTUS Citation Official disability guidelines Shoulder (Acute & Chronic), Extracorporeal shockwave therapy (ESWT) chapter 'Elbow, Hand & Wrist' and topic 'Extracorporeal shockwave therapy (ESWT).

Decision rationale: The patient presents with low back and right shoulder pain. The request is for 2 ORTHOPEDIC SHOCKWAVE. The request for authorization is dated 10/24/14. Patient has decreased range of motion to lumbar spine area. Straight leg raise is positive to the left lower extremity. Patient ambulates with a front wheel walker. Patient's medications include Naproxen, Omeprazole, Cyclobenzaprine and Topical creams. Patient is not working. The ACOEM Guidelines page 235 states the following regarding extracorporeal shockwave therapy, "Published randomized clinical trials are needed to provide better evidence for the use of many physical therapy modalities that are commonly employed. Some therapists use a variety of procedures. Conclusions regarding their effectiveness may be based on anecdotal reports or case studies. Included among these modalities is extracorporeal shockwave therapy (ESWT)." ODG Guidelines, Shoulder (Acute & Chronic), Extracorporeal shockwave therapy (ESWT) states that ESWT is recommended for "Patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment." Regarding Extracorporeal shock-wave therapy in chapter 'Elbow, Hand & Wrist' and topic 'Extracorporeal shockwave therapy (ESWT)', ODG guidelines state that it is recommended for "Patients whose pain from lateral epicondylitis (tennis elbow) has remained despite six months of standard treatment... Recommended for calcifying tendinitis but not for other shoulder disorders. Maximum of 3 therapy sessions over 3 weeks." Treater has not provided reason for the request. While MTUS and ACOEM guidelines do not discuss shockwave therapy, ODG guidelines do not indicate it for lumbar conditions. It is considered anecdotal and is still considered under study. ODG recommends ESWT "for calcifying tendinitis but not for other should disorders." There is no documentation that patient presents with calcifying tendinitis. The request is not in accordance with guideline indications. Therefore, the request IS NOT medically necessary.

Cyclobenzaprine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: The patient presents with low back and right shoulder pain. The request is for CYCOBENZAPRINE. The request for authorization is dated 10/24/14. Patient has decreased range of motion to lumbar spine area. Straight leg raise is positive to the left lower extremity. Patient ambulates with a front wheel walker. Patient's medications include Naproxen, Omeprazole, Cyclobenzaprine and Topical creams. Patient is not working. MTUS pg 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy."Treater has not provided reason for the request, nor indicated quantity. MTUS only recommends short-term use (no more than 2-3 weeks) for sedating muscle relaxants. Per UR letter dated 02/09/15, treater is requesting Cyclobenzaprine between 12/16/14 and 03/30/15. The request for Cyclobenzaprine, unspecified quantity, would exceed MTUS recommendation and does not indicate intended short-term use. Therefore, the request IS NOT medically necessary.

Flurbiprofen 10%, Capsaicin 0.025%, Camphor 2% 120gm, Ketoprofen 10%, Cyclobenzaprine 3% and Lidocaine 5% 120gm: 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 analgesic Page(s): 111-113.

Decision rationale: The patient presents with low back and right shoulder pain. The request is for FLURBIPROFEN 10% CAPSAICIN 0.025% CAMPHOR 2% 120GM, KETOPROFEN 10% CYCLOBENZAPRINE 3% AND LIDOCAINE 5% 120GM. The request for authorization is dated 10/24/14. Patient has decreased range of motion to lumbar spine area. Straight leg raise is positive to the left lower extremity. Patient ambulates with a front wheel walker. Patient's medications include Naproxen, Omeprazole, Cyclobenzaprine and Topical creams. Patient is not working. The MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Gabapentin: Not recommended. 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. Review of reports shows documentation that patient presents with osteoarthritis, for which NSAID portion of the lotion would be indicated according to MTUS guidelines. However, MTUS page 111 states that if one of the compounded topical product is not recommended, then the entire product is not. In this case, the requested

topical compound contains Cyclobenzaprine, which is not supported for topical use in lotion form per MTUS. Therefore, the request IS NOT medically necessary.