

<b>Case Number:</b>	CM15-0047748		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	10/02/2013
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2015

### 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 58-year-old male who reported an injury on 10/02/2013. The mechanism of injury was not provided. His diagnosis include lesion of ulnar nerve. Past treatments were noted to include surgery. The injured worker underwent an excision of volar ganglion cyst to the left wrist. On 02/11/2015, the injured worker had complaints of pain to his left shoulder and left elbow as well as left wrist that he rated 2/10, 4/10, and 7/10 respectively. Upon physical examination, it was noted the injured worker had tenderness to palpation to the left shoulder, left elbow, and left wrist. It was indicated the injured worker had restricted range of motion to the left shoulder and left wrist and had a positive supraspinatus test in the left shoulder and a positive Tinel's sign to the left wrist. Current medications were not included in the report. The treatment plan was noted to include chiropractic therapy, topical analgesic, extracorporeal shockwave therapy, and urine toxicology screen. The request was received for flurbi(NAP) cream LA (flurbiprofen 20%/lidocaine 5%/amitriptyline 6%) 180gm, to apply a thin layer to the affected areas BID to TID, tramadol 50mg #60, one tablet Q12H PRN, extracorporeal shockwave therapy (ESWT) of left wrist; once a week for four weeks, urine toxicology, and chiropractic evaluation and treatment; twelve (12) visits (2x6) left upper extremity. The Request for Authorization was signed 02/11/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbi(NAP) cream - LA (Flurbiprofen20%/Lidocaine 5%/Amitriptyline 6%) 180gm, to apply a thin layer to the affected areas BID to TID: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** According to the California MTUS Guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. The guidelines also state when any 1 medication in a compounded product is not recommended, the entire compounded product is not recommended. The only FDA approved topical NSAID is diclofenac and lidocaine is only indicated for post-traumatic neuralgia in the form of a patch. The clinical documentation submitted for review did not indicate the injured worker had failed antidepressant and anticonvulsants. Moreover, at least 1 of the medications is not recommended. Consequently, the request is not supported. Additionally, the request did not specify the body region and duration of use of the topical cream. As such, the request is not medically necessary.

**Tramadol 50mg #60, one tablet Q12H PRN: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Therapeutic Trial of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 78.

**Decision rationale:** According to the California MTUS Guidelines, ongoing use of opioids must be monitored with the direction of the 4 A's. The 4 A's for ongoing monitoring include analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The clinical documentation submitted for review did not indicate pain and ADLs with and without the use of tramadol and a urine drug screen was not provided to determine medication compliance. Consequently, the request is not supported. Additionally, the request is not medically necessary.

**Extracorporeal shock wave therapy (ESWT) of left wrist; once a week for four weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 203 and 371. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Extracorporeal Shock Wave Therapy (ESWT).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Low Back, Shock wave therapy and Other Medical Treatment Guidelines Other Medical Treatment Guideline or Medical Evidence: <http://www.biomedcentral.com/content/pdf/1749-799X-7-11.pdf>.

**Decision rationale:** According to the Journal of Orthopedic Surgery and Research, extracorporeal shock wave therapy (ESWT) is primarily used to treat overused tendinopathies such as proximal plantar fasciitis of the heel, lateral epicondylitis, calcific or noncalcific tendinitis of the shoulder, and patellar tendinopathy. The clinical documentation submitted for review did not note the injured worker had such conditions and there was no rationale for the requested service. Consequently, the request is not supported. As such, the request for extracorporeal shock wave therapy (ESWT) of left wrist; once a week for four weeks is not medically necessary.

**Urine toxicology:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, screening for risk of addiction (tests). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Urine Drug Testing (UDT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing; Opioids, Screening for Risk of Addiction (Tests) Page(s): 43, 90.

**Decision rationale:** According to the California MTUS Guidelines, urine toxicology screens are determine if the injured worker is compliant with opioid prescription use. The clinical documentation submitted for review did not indicate when the previous urine toxicology screen was and its results. Additionally, it was not indicated that the injured worker had been taking opioids. Consequently, the request is not supported. As such, the request for urine toxicology is not medically necessary.

**Chiropractic evaluation and treatment; twelve (12) visits (2x6) left upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58.

**Decision rationale:** According to the California MTUS Guidelines, manual therapy and manipulation, or chiropractic therapy, is recommended for chronic pain caused by musculoskeletal conditions. The guidelines go on to state that the goal for such therapy is the achievement of positive symptomatic or objective measurable gains and functional improvement that facilitate the progress in an active therapeutic exercise program. The guidelines indicate that chiropractic therapy for the upper extremity is not recommended. The clinical documentation submitted for review did not provide quantitative objective findings regarding the injured worker's current functional status nor that the injured worker will participate in an active therapeutic exercise program. Consequently, the request is not supported. Moreover, the

guidelines do not recommend chiropractic therapy for the upper extremity. As such, the request for chiropractic evaluation and treatment; twelve (12) visits (2x6) left upper extremity is not medically necessary.