

Case Number:	CM15-0088156		
Date Assigned:	05/12/2015	Date of Injury:	05/10/2011
Decision Date:	07/09/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/07/2015

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 52-year-old female who sustained an industrial injury on 5/10/11. The injured worker was diagnosed as having cervical spine musculoligamentous strain/sprain with radiculitis, right shoulder strain/sprain tendinitis, right elbow lateral and medial epicondylitis, rule out right elbow carpal tunnel syndrome, right wrist strain/sprain rule out right carpal tunnel syndrome. Currently, the injured worker was with complaints of pain in the neck, right shoulder and right elbow. Previous treatments included aquatic physical therapy and activity modification. The injured workers pain level was noted as 8/10. Objective findings were notable for cervical spine tenderness to palpation over paraspinal muscles with restricted range of motion, right shoulder tenderness to palpation with restricted range of motion and right wrist with tenderness to palpation. The plan of care was for physical therapy, extracorporeal shockwave therapy, and medication prescriptions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy twelve (12) sessions (2x6) to the cervical spine and right upper extremity:

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: This patient complains of pain in the neck, right shoulder and right elbow. The current request is for Physical therapy twelve (12) sessions (2x6) to the cervical spine and right upper extremity. Previous treatments included aquatic therapy, physical therapy, medications and activity modification. The patient is TTD. The MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. " MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. " Objective findings on 04/03/15 were notable for cervical spine tenderness to palpation over paraspinal muscles with restricted range of motion, right shoulder tenderness to palpation with restricted range of motion and right wrist with tenderness to palpation. The treatment plan was for 12 PT sessions. The medical file includes three physical therapy evaluation reports dated 11/12/14, 01/23/15 and 04/23/15. The exact number of completed physical therapy visits to date and the objective response to therapy were not documented in the medical reports. QME report from 10/31/15 stated that the patient started physical therapy on 10/03/14. In this case, there is no report of recent surgery, new injury, new diagnoses, or new examination findings to substantiate the current request. Furthermore, it appears the patient has participated in an undisclosed number of PT treatments in the past and the request for 12 additional sessions exceeds what is recommended by MTUS. The requested physical therapy IS NOT medically necessary.

Extracorporeal Shock-wave Therapy four (4) sessions (1x4) to the bilateral shoulders:
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 Extracorporeal Shock-wave Therapy (ESWT) section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder Chapter, ESWT.

Decision rationale: This patient complains of pain in the neck, right shoulder and right elbow. The current request is for Extracorporeal Shock-wave Therapy four (4) sessions (1x4) to the bilateral shoulders. Previous treatments included aquatic therapy, physical therapy, medications and activity modification. The patient is TTD. The MTUS Guidelines and ACOEM Guidelines do not discuss extracorporeal shock wave treatments. The ODG Guidelines under ESWT under the Shoulder Chapter states, "Recommended for calcifying tendinitis, but not for other disorders, for patients with calcifying tendinitis of the shoulder in homogeneous deposits, quality evidence have found extracorporeal shock wave therapy equivalent or better than surgery and it may be given priority because of its non-invasiveness. " ODG guidelines under the low back chapter do

not recommend extracorporeal shockwave therapy. ODG guideline supports EWST for calcific tendinitis of the shoulder, lateral epicondylitis and low energy EWST for plantar fasciitis. Objective findings on 04/03/15 were notable for cervical spine tenderness to palpation over paraspinal muscles with restricted range of motion, right shoulder tenderness to palpation with restricted range of motion and right wrist with tenderness to palpation. The treatment plan was for ESWT for the bilateral shoulders. The medical reports do not include imaging of the shoulder. The patient has positive impingement test of the right shoulder with tenderness and restricted ROM. There is no indication of the patient having calcifying tendonitis, as indicated by ODG guidelines. Therefore, the request for shockwave therapy is not in accordance with ODG guidelines and IS NOT medically necessary.

Consultation with pain management specialist: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines 2nd Ed. , 2004, Chapter 7 , Independent Medical Examinations and Consultations.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch:7 page 127.

Decision rationale: This patient complains of pain in the neck, right shoulder and right elbow. The current request is for Consultation with pain management specialist. Previous treatments included aquatic therapy, physical therapy, medications and activity modification. The patient is TTD. American College of Occupational and Environmental Medicine ACOEM, 2nd Edition, 2004 ACOEM guidelines, chapter 7, page 127 state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. In regard to the request for consultation with a pain management specialist, the referral is appropriate. This patient presents with continuing unresolved neck and shoulder pain. This patient's chronic pain symptoms could benefit from additional specialist treatment and such consultations are supported by guidelines at the provider's discretion. Therefore, the request IS medically necessary.

Flurbi NAP cream-LA flurbiprofen 20%/lidocaine 5%/amitriptyline 5%: 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: This patient complain of pain in the neck, right shoulder and right elbow. The current request is for Flurbi NAP cream-LA Flurbiprofen 20%/lidocaine 5%/amitriptyline 5%. Previous treatments included aquatic therapy, physical therapy, medications and activity modification. The patient is TTD. For Lidocaine, the MTUS guidelines, pages 111, do not support any other formulation than topical patches. The MTUS guidelines do not support the use of topical NSAIDs such as Flurbiprofen for axial, spinal pain, but supports its use for peripheral joint arthritis and tendinitis. Objective findings on 04/03/15 were notable for cervical spine

tenderness to palpation over paraspinal muscles with restricted range of motion, right shoulder tenderness to palpation with restricted range of motion and right wrist with tenderness to palpation. In this case, Lidocaine is not supported by MTUS in any topical formulation other than a patch. Flurbiprofen is only recommended for peripheral joint arthritis and tendinitis which this patient does not suffer from. MTUS also specifically states that anti-depressants such as Amitriptyline are not recommended in any topical formulation. The Guidelines also provide clear discussion regarding topical compounded creams on pg. 111 stating that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Hence, this request IS NOT medically necessary.

Gabacyclotram gabapentin 10%/Cyclobenzaprine 6%/tramadol 10% 180gm: 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 analgesics Page(s): 111-113.

Decision rationale: This patient complains of pain in the neck, right shoulder and right elbow. The current request is for Gabacyclotram gabapentin 10%/Cyclobenzaprine 6%/tramadol 10% 180gm. Previous treatments included aquatic therapy, physical therapy, medications and activity modification. The patient is TTD. MTUS guidelines has the following regarding topical creams (p111, chronic pain section): "Topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety". 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. Gabapentin: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. Cyclobenzaprine is a muscle relaxant and is not supported for any topical formulation. Objective findings on 04/03/15 were notable for cervical spine tenderness to palpation over paraspinal muscles with restricted range of motion, right shoulder tenderness to palpation with restricted range of motion and right wrist with tenderness to palpation. The treater does not provide a rationale for this medication. MTUS Guidelines page 111 do not recommend a compounded product if one of the compounds are not indicated for use. In this case, neither Gabapentin nor Cyclobenzaprine are indicated in a topical formulation. Therefore, the requested compounded medication IS NOT medically necessary.