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| Case Number: | CM15-0088545 | | |
| Date Assigned: | 05/14/2015 | Date of Injury: | 08/26/2013 |
| Decision Date: | 07/09/2015 | UR Denial Date: | 04/24/2015 |
| 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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational 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 56-year-old male with an industrial injury dated 08/26/2012 to 08/26/2013 (cumulative trauma). His diagnoses included cervical spine musculoligamentous strain/sprain, rule out disc protrusion, thoracic spine musculoligamentous strain/sprain, lumbar spine musculoligamentous strain/sprain with radiculitis, rule out disc protrusion, right shoulder strain/sprain, rule out internal derangement, left shoulder impingement/tendinopathy, bilateral elbow strain/sprain and lateral epicondylitis, bilateral wrist strain/sprain, carpal tunnel syndrome, right knee/strain/sprain, meniscal tear, right foot strain/sprain, situational depression/anxiety and sleep disturbance secondary to pain. Prior treatments included physical therapy, extracorporeal shockwave therapy, and diagnostics. He presents on 01/15/2014 with complaints of pain in neck back, bilateral shoulder, elbows, forearms, right knee and right ankle and foot. The injured worker rated his pain level in all areas decreased since the last visit with the exception of lower back, which had remained the same and right ankle/foot, which had increased from 3/10 at last visit to 7-8/10. Physical exam revealed tenderness with restricted range of motion in the cervical, thoracic and lumbar spine. Cervical compression test was positive. There was tenderness over bilateral shoulders with restricted range of motion. Impingement and supraspinatus tests were positive. There was also tenderness of bilateral elbows, bilateral forearms, bilateral wrists, bilateral hands, right ankle and right foot. Right knee was tender with restricted range of motion. McMurray's test was positive. Treatment plan included evaluation and chiropractic therapy to cervical, thoracic and lumbar spine; bilateral upper extremities and right knee, pain medication, topical analgesics, extracorporeal shockwave therapy to the left shoulder and urine toxicology.

IMR ISSUES, DECISIONS AND RATIONALES

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

ECSWT (extracorporeal shock wave treatment), Left Shoulder - Completed (2/25/14, 2/7/14, 3/11/14, 3/18/14): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder and Knee, ESWT Other Medical Treatment Guideline or Medical Evidence: pub med search ESWT and wrist.

Decision rationale: MTUS does not specifically refer to Electric Shockwave therapy. The ODG guidelines were consulted for ESWT treatment of the shoulder and only recommended Shoulder ESWT when: 1) Patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. 2) At least three conservative treatments have been performed prior to use of ESWT. These would include a. Rest, b. Ice, c. NSAIDs, d. Orthotics, e. Physical Therapy, e. Injections (Cortisone). Medical records does not detail what conservative therapy was tried and does not provide any detail regarding the physical therapy of the shoulder. ODG does not specify shock wave therapy for wrist and cervical neck, but does detail therapy of lumbar spine, Not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. Medical documents do not provide sufficient details of failed conservative therapy for the shoulder. As such, the request for ECSWT (Extracorporeal Shock Wave Therapy), is not medically necessary.

Fluriflex 180 gm (dispensed between 1/15/2014 and 1/22/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: Fluriflex is a topical compound made of Flurbiprofen and Cyclobenzaprine. ODG recommends usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. " MTUS states regarding topical muscle relaxants, "Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. " Topical cyclobenzaprine is not indicated for this usage, per MTUS. MTUS states that the only FDA-approved NSAID medication for topical use includes diclofenac, which is indicated for relief of osteoarthritis pain in joints. Flurbiprofen would not be indicated for topical use in this case. This compound contains two substances which are not indicated for topical usage per MTUS. As such, the request is not medically necessary.

TGHot 180 gm (dispensed between 1/15/2014 and 1/22/15) [topical compound tramadol, gabapentin, menthol, capsaicin]: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: Topical Guide Hot or TG Hot is a compound made from Tramadol/ Gabapentin /Menthol /Camphor /Capsaicin. ODG recommends usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. " MTUS states that the only FDA- approved NSAID medication for topical use includes diclofenac, which is indicated for relief of osteoarthritis pain in joints. Tramadol would not be indicated for topical use in this case. MTUS states that topical Gabapentin is "Not recommended. " Additionally, MTUS clearly states Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this compound Tramadol and Gabapentin are not indicated for topical usage. As such, the request is not medically necessary.

Tramadol 50 mg Qty 60 (dispensed between 1/15/2014 and 1/22/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol; Opioids Page(s): 74-123. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) - Medications for acute pain (analgesics), Tramadol (Ultram®).

Decision rationale: Ultram is the brand name version of tramadol, which is classified as central acting synthetic opioids. MTUS states regarding tramadol that "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." ODG further states, "Tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/ acetaminophen. " The treating physician did not provide sufficient documentation that the patient has failed a trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, no documentation was provided which discussed the setting of goals for the use of tramadol prior to the initiation of this medication. As such, the request for tramadol is not medically necessary.

Urine toxicology - (Completed 01/26/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction Page(s): 94. Decision based on Non-MTUS Citation Official Disability Guidelines: Criteria for use of Urine Drug Testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Urine drug testing (UDT).

Decision rationale: MTUS states that use of urine drug screening for illegal drugs should be considered before therapeutic trial of opioids are initiated. Additionally, Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). Would indicate need for urine drug screening. ODG further clarifies frequency of urine drug screening: Low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Moderate risk for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. High risk of adverse outcomes may require testing as often as once per month. There is insufficient documentation provided to suggest issues of abuse, misuse, or addiction. The patient is classified as low risk. As such, the current request for retrospective urinalysis drug screening is not medically necessary.