

<b>Case Number:</b>	CM14-0160290		
<b>Date Assigned:</b>	10/03/2014	<b>Date of Injury:</b>	12/01/2012
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	09/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Louisiana. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 38 year old male who was injured on 12/01/2012 due to a cumulative trauma. Prior treatment history has included tramadol 50 mg, Fluriflex 180 mg, physical therapy, 2 extracorporeal shockwave therapy treatments which helped with the pain. The patient underwent a median nerve decompression. Progress report dated 08/14/2014 documented the patient to have complaints of pain in the right elbow as well as pain and numbness in the right wrist/hand. He rated his pain as a 3/10 in the right elbow. He rated his right wrist pain a 7/10 and the left wrist a 2/10. On exam, there is grade 2 tenderness to palpation of bilateral elbows and he had full range of motion. On examination of bilateral wrists, there was grade 3 tenderness to palpation on the right and grade 2 tenderness on the left. He had restricted range of motion and positive Tinel's and Phalen's sign. The patient had decreased motor of the right opponens muscle and decreased sensation over the thenar of the right hand. The patient was diagnosed with bilateral elbow tendinitis; left carpal tunnel syndrome and status post right carpal tunnel release on 08/05/2013 with residuals. He was prescribed topical medications and recommended for extracorporeal shockwave therapy to the right wrist. Prior utilization review dated 09/18/2014 states the requests for Physical therapy-bilateral wrists and elbows (2x weekly for 4 weeks) Quantity: 8; Tramadol 50mg #40; Fluriflex 180gm; and Extracorporeal shockwave therapy-right wrist (1x week for 6 weeks) Quantity: 6 are denied guideline criteria has not been met.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy-bilateral wrists and elbows (2x week for 4 weeks) Quantity: 8: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and hand, Physical therapy

**Decision rationale:** Based on the Chronic Pain Medical Treatment Guidelines, Physical Therapy is recommended for a time-limited treatment plan with defined functional goals, frequent assessments and modification of the treatment plan based upon progression. Guidelines require documentation of objective improvement with previous treatment, function deficits, functional goals, and a statement identifying why an independent home exercise program would be insufficient. In this case, the supporting documentation indicated a considerable amount of physical therapy and no explanation of why a home exercise plan would be beneficial for further recovery therefore, this request is not medically necessary.

**Tramadol 50mg #40:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-97.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guideline, Tramadol, a synthetic opioid affecting the nervous system, is recommended as the standard care of treatment for moderate to severe pain for short-term use. There is a lack of supporting documentation indicating the necessity of Tramadol to treat musculoskeletal pain and long term use is not recommended by guidelines. Therefore, the request is not medically necessary.

**Fluriflex 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 NSAIDs (Non-steroidal anti-inflammatory drugs Page(s): 67-73.

**Decision rationale:** Based on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. In this case, the non-steroidal anti-inflammatory drug, Fluriflex, is not FDA approved for the use as a topical therefore, this request is not medically necessary.

**Extracorporeal shockwave therapy-right wrist (1x week for 6 weeks) Quantity: 6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.ncbi.nlm.nih.gov/pubmed/22433113](http://www.ncbi.nlm.nih.gov/pubmed/22433113)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Extracorporeal shock wave therapy

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, The application of Extracorporeal Shockwave therapy in musculoskeletal disorders has been around for more than a decade and is primarily used in the treatment of sports related over-use tendinopathy such as proximal plantar fasciitis of the heel, lateral epicondylitis of the elbow, calcific or non-calcific tendonitis of the shoulder and patellar tendinopathy etc. In this case, no indications were found for the use of extracorporeal Shockwave therapy for carpal tunnel, tendonitis or neuritis therefore, this request is not medically necessary.