

Case Number:	CM15-0064936		
Date Assigned:	04/13/2015	Date of Injury:	12/22/2003
Decision Date:	05/15/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/06/2015

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: Pennsylvania
 Certification(s)/Specialty: Internal 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 64 year old female, who sustained an industrial injury on 12/22/2003. She reported a fall onto the right knee with injury to the knee, back and shoulder. Diagnoses include lumbar pain, left rotator cuff tear, left shoulder pain and right knee pain. Treatments to date included medication. MRI of the left shoulder on 1/15/15 showed acromioclavicular osteoarthritis, bicipital tenosynovitis, and supraspinatus/infraspinatus/subscapularis tendinosis. At a visit on 2/25/15, the injured worker complained of left shoulder pain and right knee pain. The lumbar spine was documented to cause no complaints. Physical examination showed painful decreased range of motion in both the shoulder and the right knee with a positive McMurray's sign on the right. Medications included naproxen, pantoprazole, cyclobenzaprine, and topical creams. The plan of care included topical compound cream, acupuncture, chiropractic therapy, orthopedic surgeon consultation, shockwave therapy to the left shoulder, and a hot/cold pack for the right knee. Work status was noted as off work. On 3/20/15, Utilization Review (UR) non-certified requests for shockwave therapy 1x/week x 3 weeks left shoulder, furbiprofen 20%/baclofen 5%/dexamethasone 2%/capsaicin 0.25% 180 grams, gabapentin 10%/amitriptyline 10%/bupivacaine 5% 180 grams, and DME hot/cold pack right knee. UR cited the MTUS, ACOEM, and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave Therapy 1 time a week for 3weeks Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 224. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter: ESWT.

Decision rationale: The ACOEM shoulder chapter includes a reference regarding use of shock wave therapy for chronic calcifying tendinitis of the shoulder, but does not make specific recommendation regarding this modality. The ODG states that criteria for use of extracorporeal shock wave therapy (ESWT) for the shoulder include pain from calcifying tendinitis of the shoulder that has remained despite six months of standard treatment, at least three conservative treatments have been performed prior to the use of ESWT, and lack of certain specific contraindications. In this case, there was no documentation of calcifying tendinitis of the shoulder; the MRI submitted did not describe any calcification of the tendons. There was no documentation of performance of at least three conservative treatments. Due to lack of indication, the request for Shockwave Therapy 1 time a week for 3weeks Left Shoulder is not medically necessary.

Flurbiprofen 20%, Baclofen 5 %, Dexamethasone 2 % Capsaicin 0.25 % 180 Grams:
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 medications for chronic pain, topical analgesics Page(s): 60, 111-113.

Decision rationale: This injured worker had knee and shoulder pain. The site of application of this topical compounded cream and the directions for use were not specified. Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There was no documentation of neuropathic pain or trial and failure of antidepressants and anticonvulsants. If any compounded product contains at least one drug or drug class that is not recommended, the compounded product is not recommended. Per the MTUS page 60, medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. In addition to any other reason for lack of medical necessity for these topical agents, they are not medically necessary on this basis at minimum. Topical NSAIDs are indicated for osteoarthritis and tendinitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. Topical nonsteroidals are not recommended for neuropathic pain. Note that topical flurbiprofen is not FDA approved, and is therefore experimental and cannot be presumed as safe and efficacious. Non-FDA approved

medications are not medically necessary. This injured worker has also been prescribed an oral NSAID, naproxen, which is duplicative and potentially toxic. Baclofen is not recommended in topical form. Capsaicin has some indications, in the standard formulations readily available without custom compounding. The MTUS also states that capsaicin is only recommended when other treatments have failed. The treating physician did not discuss the failure of other, adequate trials of conventional treatments. It may be used for treatment of osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in high doses. As multiple drugs in this compounded topical cream are not recommended, the compound is not recommended. As such, the request for Flurbiprofen 20%, Baclofen 5 %, Dexamethasone 2 % Capsaicin 0.25 % 180 Grams is not medically necessary.

Gabapentin 10 %, Amitriptyline 10 %, Bupivacaine 5 % 180 Grams ;: 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 medications for chronic pain, topical analgesics Page(s): 60, 111-113.

Decision rationale: This injured worker had knee and shoulder pain. The site of application of this topical compounded cream and the directions for use were not specified. Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There was no documentation of neuropathic pain or trial and failure of antidepressants and anticonvulsants. If any compounded product contains at least one drug or drug class that is not recommended, the compounded product is not recommended. Per the MTUS page 60, medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. In addition to any other reason for lack of medical necessity for these topical agents, they are not medically necessary on this basis at minimum. Gabapentin is an antiepileptic drug and is not recommended in topical form; there is no peer-reviewed literature to support use. As the compound contains a drug which is not recommended, the compound is not recommended. As such, the request for Gabapentin 10 %, Amitriptyline 10 %, Bupivacaine 5 % 180 Grams is not medically necessary.

DME Hot/Cold Pack, Right Knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338, Chronic Pain Treatment Guidelines.

Decision rationale: This injured worker had right knee pain. The ACOEM Guidelines page 338 recommend cold packs during the first few days for knee pain, and heat packs thereafter. There is no recommendation for any specific device in order to accomplish this. Heat and cold can be applied to the skin using simple home materials, e.g. ice and hot water, without any formal

medical device or equipment. At-home heat or cold packs may be used before or after exercises. There may be some indication for heat or cold therapy, but the recommendation is for home application of non-proprietary, low-tech, therapy in the context of functional restoration. In this case, there was no discussion of an exercise program or functional restoration program. Due to lack of indication, the request for DME Hot/Cold Pack, Right Knee is not medically necessary.