

Case Number:	CM15-0066904		
Date Assigned:	04/14/2015	Date of Injury:	03/20/2011
Decision Date:	06/29/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	04/08/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 64-year-old female patient who sustained an industrial injury on 3/20/11. The diagnoses include cervical spine musculoligamentous strain/sprain, cervical spine disc disease exacerbation, left shoulder strain/sprain exacerbation and left shoulder impingement syndrome. Per the doctor's note dated 3/13/2015, she was asymptomatic regarding her neck and left shoulder. The physical examination revealed restricted range of motion of the neck and left shoulder. The medications list includes tylenol, advil and topical compound creams. Treatments to date have included physical therapy, topical cream, activity modification, and analgesics. The plan of care was for physical therapy, shockwave therapy, medication prescriptions and a follow up appointment at a later date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20%, Lidocaine 5%, Amitriptyline %5 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, pages 111-113 Flurbiprofen is a NSAID.

Decision rationale: Flurbiprofen 20%, Lidocaine 5%, Amitriptyline %5 180gm. The MTUS Chronic Pain Guidelines regarding topical analgesics state, "Largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, and antidepressants). (Argoff, 2006) 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. Topical NSAIDs- There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended, as there is no evidence to support use. Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Non-neuropathic pain: Not recommended. MTUS guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. Failure of antidepressants and anticonvulsants for this injury is not specified in the records provided. Intolerance to oral medication is not specified in the records provided. In addition, as cited above, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen and amitriptyline are not recommended by MTUS for topical use as cited above because of the absence of high- grade scientific evidence to support their effectiveness. The medical necessity of Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5% 180gm is not fully established for this patient.

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: Gabapentin 10%, Cyclobenzaprine 6%, Tramadol 10% 180gm. Cyclobenzaprine is a muscle relaxant and gabapentin is anti convulsant. The cited Guidelines regarding topical analgesics state, "Largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, and antidepressants). (Argoff, 2006) 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. Topical NSAIDs- There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended, as there is no evidence to support use. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. Gabapentin: Not recommended. There is no peer-reviewed literature to support use."The cited guidelines

recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. Failure of antidepressants and anticonvulsants for this injury is not specified in the records provided. Intolerance to oral medication is not specified in the records provided. In addition, as cited above, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Cyclobenzaprine and gabapentin are not recommended by the cited guidelines for topical use as cited below because of the absence of high-grade scientific evidence to support their effectiveness. The medical necessity of Gabapentin 10%, Cyclobenzaprine 6%, Tramadol 10% 180gm is not fully established for this patient.

Physical therapy 2 x 6 for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical therapy guidelines.

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

Decision rationale: Physical therapy 2 x 6 for the left shoulder. The cited guidelines recommend up to 9-10 physical therapy visits for this diagnosis. Per the records provided, patient has had unspecified numbers of physical therapy visits for this injury. There is no evidence of significant progressive functional improvement from the previous physical therapy visits that is documented in the records provided. Per the cited guidelines, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of Physical therapy 2 x 6 for the left shoulder is not established for this patient at this time.

Electrical shockwave therapy 1 x 4 to the left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for the use of Extracorporeal Shock Wave Therapy (ESWT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, initial care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Shoulder (updated 05/04/15) Extracorporeal shock wave therapy (ESWT).

Decision rationale: Per the cited guidelines "Some medium quality evidence supports manual physical therapy, ultrasound, and high energy extracorporeal shock wave therapy for calcifying tendinitis of the shoulder." Evidence of calcifying tendinitis is not specified in the records provided. Per the cited guidelines, there is no high-grade scientific evidence to support the use of shockwave treatment for this diagnosis. Response to previous conservative therapy including physical therapy and pharmacotherapy is not specified in the records provided. The medical necessity of Electrical shockwave therapy 1 x 4 to the left shoulder is not fully established in this patient.