MAXIMUS Federal Services

Case Number:	CM15-0067618		
Date Assigned:	04/15/2015	Date of Injury:	06/26/2013
Decision Date:	05/19/2015	UR Denial Date:	03/28/2015
Priority:	Standard	Application Received:	04/09/2015

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 55 year old male who sustained an industrial injury on 6/26/2013 due to a fall. Diagnoses include aggravation of prior symptomatic cervical disc protrusions; cervical myoligamentous sprain/strain with residual cervical myofascial pain; bilateral shoulder strain with bursitis and traumatic impingement syndrome; full thickness tear of the right and left shoulder rotator cuffs; bilateral elbow contusions/abrasions; traumatic mallet finger right index digit; lumbosacral myoligamentous sprain/strain; mechanical discogenic low back pain with lumbar spine; contusion right knee with residual patellofemoral pain syndrome; oblique tear, medial right knee; and rectus abdominis muscle strain/contusion. Recent magnetic resonance imaging studies, bilateral shoulders, was stated to have been done on 4/23/2014, and of the right knee and abdomen on 5/6/2014. X-rays of the cervical spine, bilateral shoulders, bilateral elbows/hands/fingers, lumbar spine, and right knee were stated to have been done on 4/11/2014. His treatments have included chiropractic treatment, physical therapy, restricted work duties, and medication. The history notes other industrial injuries, prior to this injury, which include: cervical myoligamentous sprain/strain; cervical disc protrusion; and right shoulder strain with questionable impingement syndrome. Also noted are non-occupational, underlying orthopedic regional abnormalities which include degenerative acromioclavicular joint osteoarthritis of the bilateral shoulders. Progress notes from August 2014 note prescription of norco and temporarily totally disabled work status. Progress notes from October 2014 not prescription of tramadol and continued temporarily totally disabled work status. Tramadol was noted to provide decrease in pain, greater range of motion and greater tolerance to activity/exercise. A pain contract was

discussed and there was discussion regarding screening for aberrant behavior. A urine toxicology screen was requested. The progress notes from 3/12/2015 noted frequent, moderate achy neck pain; constant, moderate achy low back, bilateral shoulder, and right knee pain. Work status was noted as modified duty. The physician's requests for treatments included Tramadol, 2 different topical analgesic compound creams, extra-corporeal shock wave therapy, a trigger point impedance imaging study, and localized intense neuro-stimulation therapy. On 3/28/15, Utilization Review (UR) non-certified the requests now under Independent Medical Review, citing the MTUS and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50 mg, ninety count: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: Tramadol is a centrally acting synthetic opioid analgesic which is not recommended as a first line oral analgesic. The MTUS guidelines for use of opioids recommend prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug- taking behaviors. This injured worker was previously prescribed norco, and is now prescribed tramadol for use as needed. The documentation reflects improvement in pain and improvement in activities as a result of tramadol. Work status had been temporarily totally disabled, and work status is now noted as modified duty. The documentation includes discussion of an opioid contract, urine drug screening, discussion of risks, and screening for aberrant behavior. Dose of tramadol was from 300 mg daily in October 2014 to 50 mg three times daily as needed. Due to demonstration of functional improvement, the request for tramadol is medically necessary.

Topical compounded NPC1 to include Gabapentin 10%, Amitriptyline 10% and Bupivacaine 5% in cream base, 210 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines medications for chronic pain, opical analgesics Page(s): 60, 111-113.

Decision rationale: Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. 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. The MTUS and ODG do not address amitriptyline and bupivacaine in topical form. As this compound contains gabapentin, which is not recommended in topical form, the compound is not recommended. As such, the request for topical compounded NPC1 to include Gabapentin 10%, Amitriptyline 10% and Bupivacaine 5% in cream base, 210 grams is not medically necessary.

Compounded MPHCC1 to include flurbiprofen 20%, baclofen 5%, dexamethasone 2%, menthol 2%, camphor 2% and capsaicin 0.025% in cream base 210 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines medications for chronic pain, opical analgesics Page(s): 60, 111-113. Decision based on Non-MTUS Citation Uptodate: camphor and menthol: drug information. In UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. 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. Flurbiprofen is a non-steroidal anti-inflammatory drug (NSAID). 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 non-steroidals 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. 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. The MTUS and ODG are silent with regard to menthol and camphor. They may be used for relief of dry, itchy skin. These agents carry warnings that they may cause serious burns. As multiple agents in this compounded topical product are not recommended, the compound is not recommended. As such, the request for compounded MPHCC1 to include flurbiprofen 20%, baclofen 5%, dexamethasone 2%, menthol 2%, camphor 2% and capsaicin 0.025% in cream base 210 grams is not medically necessary.

Unknown extracorporeal shockwave therapy sessions: 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 (ODG), Knee & Leg Chapter.

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: extracorporeal shock wave therapylow back chapter: shock wave therapy knee chapter: extracorporeal shock wave therapy and Other Medical Treatment Guidelines Wang, Ching-Jen. Extracorporeal shockwave therapy in musculoskeletal disorders. In Journal of Orthopeaedic Surgery and Research 2012, 7:11.

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. Per the ODG, shock wave therapy for the low back is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. Regarding the knee, shock wave therapy is under study for patellar tendinopathy and for long-bone hypertrophic nonunions. New data suggests that extracorporeal shockwave therapy is ineffective for treating patellar tendionopathy, compared to the current standard of care emphasizing multimodal physical therapy focused on muscle retraining, joint mobilization, and patellar taping. Based on this information, shockwave therapy to the knee would be considered experimental and therefore not medically necessary. Shock wave therapy is recommended for calcifying tendinitis of the shoulder but not for other shoulder disorders. There is no evidence of benefit in non-calcific tendonitis of the rotator cuff, or other shoulder disorders, including frozen shoulder or breaking up adhesions. The additional reference cited notes that the FDA has approved specific shockwave devices for the treatment of plantar fasciitis and lateral epicondylitis. Other uses of ESWT have been studied off-label. As the use of shock wave therapy to the cervical spine is considered experimental and is not FDA approved, the request for shock wave therapy to the cervical spine is not medically necessary. This injured worker had chronic neck, back, shoulder, and knee pain. The site to be treated with shock wave therapy was not specified, and could potentially represent an area of the body for which shock wave therapy is not recommended. Shock wave therapy to the neck, low back and knee is not recommended. There was no documentation of calcific tendinitis of the shoulder, which is the only shoulder disorder for which shock wave therapy is recommended. Due to lack of sufficiently specific prescription and lack of indication, the request for shock wave therapy is not medically necessary.

One trigger point impedance imaging: 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), Low Back Chapter.

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 chapter: trigger point impedance imaging, hyperstimulation analgesia.

Decision rationale: Per the ODG, trigger point impedance imaging is not recommended. It is used in association with hyperstimulation analgesia, which is also not recommended. The specific indication and reason for this test was not provided by the treating physician. Due to lack of recommendation by the guidelines, the request for one trigger point impedance imaging is not medically necessary.

Unknown localized intense neurostimulation therapy (LINT) sessions: 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).

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 chapter: trigger point impedance imaging, hyperstimulation analgesia.

Decision rationale: Per the ODG, hyperstimulation analgesia is not recommended until there are higher quality studies. Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings, thus causing the release of endogenous endorphins. The procedure requires impedance mapping of the back. Initial results are promising, but only from two low quality studies sponsored by the manufacturer. Due to lack of recommendation by the guidelines, the request for localized intense neurostimulation therapy is not medically necessary.