

Case Number:	CM15-0092187		
Date Assigned:	05/15/2015	Date of Injury:	08/26/2013
Decision Date:	09/23/2015	UR Denial Date:	04/26/2015
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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 (IW) is a 56-year-old male who sustained an industrial injury on 08/26/2013. Diagnoses include cervical, right shoulder, left elbow and bilateral wrist strain/sprain; lumbosacral strain/sprain with radiculopathy, left shoulder strain/sprain, tendinosis and impingement syndrome; right elbow strain/sprain and lateral epicondylitis; bilateral carpal tunnel syndrome and right knee strain/sprain and meniscal tear. Treatment to date has included medications, acupuncture, physical and chiropractic therapy and extracorporeal shockwave therapy. He also saw a psychiatrist and psychologist. A Functional Capacity Evaluation was performed 9/30/13. Electromyography/nerve conduction velocity (EMG/NCV) testing of the upper extremities on 9/25/13 showed borderline study for median sensory neuropathy in the bilateral wrists, mild ulnar sensory neuropathy in the bilateral wrists and significant cervical paraspinal muscle spasms and/or cervical nerve root irritation/traction injury. According to the progress notes dated 9/26/14, the IW reported neck pain; low back pain; right shoulder pain; left shoulder pain; right elbow pain; left elbow pain; bilateral wrist pain and right knee pain associated with swelling, popping, clicking and giving way. On examination, there was decreased range of motion to the neck, back, bilateral shoulders, right elbow and right knee. X-rays of the right elbow and foot were normal. MRI of the right shoulder on 12/21/13 revealed osteoarthritis of the acromioclavicular joint and tendinopathy; MRI of the right knee on the same date showed a medial meniscus tear and mild chondromalacia. EMG/NCV testing on 1/6/14 was positive for lumbar paraspinal muscle spasms and/or lumbar nerve roots irritation/traction injury. A retrospective request was made for one prescription of Fluriflex 180Gms, one prescription of

TGHOT 180Gms one prescription of Tramadol 50mg, #60, 1 interferential unit, 1 cold therapy unit and EMG/NCV testing of the upper and lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for 1 prescription of Fluriflex 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Topical NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

Decision rationale: The 56-year-old patient complains of right knee pain, left shoulder pain, right elbow pain radiating to the right wrist with right thumb and index finger numbness, and non-radiating low back pain, as per QME report dated 03/03/15. The request is for RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION OF FLURIFLEX 180gm. There is no RFA for this case, and the patient's date of injury is 08/26/13. Diagnoses, as per QME report dated 03/03/15, included continuous trauma injury to the right knee with MRI showing tear of right medial meniscus, left shoulder sprain/strain, lumbosacral sprain/strain, left elbow lateral epicondylitis, and right carpal tunnel syndrome. As per progress report dated 07/27/15 (after the UR denial date of 04/26/15), the lower back pain is rated at 5/10, the left shoulder pain is rated at 7/10, the right elbow pain is rated at 7-8/10, and right knee pain is rated at 7/10. Medications included Flurbi (NAP) cream. The patient is working, as per QME report dated 03/03/15. Fluriflex cream includes Flurbiprofen and Cyclobenzaprine. MTUS Chronic Pain Guidelines under Topical analgesics has the following on page 111 "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." For Flurbiprofen, MTUS states, the efficacy in clinical trials for this treatment modality has been inconsistent, and most studies are small and of short duration. Topical NSAIDs had been shown in the meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. Indications for use are osteoarthritis and tendinitis (in particular, that of the knee and elbow) or other joints that are amendable to topical treatment. In this case, a prescription for Fluriflex cream is first noted in progress report dated 02/19/14. In the report, the treater states "Topical medications were prescribed in order to minimize neurovascular complications; to avoid complications associated with the use of narcotic medications, as well as upper GI bleeding from the use of NSAID medications." The treater, however, does not document the efficacy of Fluriflex in terms of improvement in function and reduction in pain. The patient does suffer from peripheral joint pain and may benefit from the use of topical NSAID such as Flurbiprofen. However, MTUS recommends against the use of Cyclobenzaprine in topical form. Furthermore, the Guidelines state clearly, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Hence, this request IS NOT medically necessary.

Retrospective request for 1 prescription of TGHOT 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.

Decision rationale: The 56-year-old patient complains of right knee pain, left shoulder pain, right elbow pain radiating to the right wrist with right thumb and index finger numbness, and non-radiating low back pain, as per QME report dated 03/03/15. The request is for RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION OF TGHOT 180gm. There is no RFA for this case, and the patient's date of injury is 08/26/13. Diagnoses, as per QME report dated 03/03/15, included continuous trauma injury to the right knee with MRI showing tear of right medial meniscus, left shoulder sprain/strain, lumbosacral sprain/strain, left elbow lateral epicondylitis, and right carpal tunnel syndrome. As per progress report dated 07/27/15 (after the UR denial date of 04/26/15), the lower back pain is rated at 5/10, the left shoulder pain is rated at 7/10, the right elbow pain is rated at 7-8/10, and right knee pain is rated at 7/10. Medications included Flurbi (NAP) cream. The patient is working, as per QME report dated 03/03/15. MTUS Chronic Pain Guidelines under Topical analgesics has the following on page 111 "Recommended as an option as indicated below. 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. (Namaka, 2004)...Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, "adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists," agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (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. Gabapentin: Not recommended. There is no peer-reviewed literature to support use." In this case, a prescription for Fluriflex cream is first noted in progress report dated 05/21/14. In the report, the treater states "Topical medications were prescribed in order to minimize neurovascular complications; to avoid complications associated with the use of narcotic medications, as well as upper GI bleeding from the use of NSAID medications." The treater, however, does not document the efficacy of TGHOT in terms of improvement in function and reduction in pain. Additionally, this topical formulation contains Gabapentin and MTUS does not support its use in topical form. The Guidelines also state clearly, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Hence, this request IS NOT medically necessary.

Retrospective request for 1 prescription of Tramadol 50 #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88, 89.

Decision rationale: The 56-year-old patient complains of right knee pain, left shoulder pain, right elbow pain radiating to the right wrist with right thumb and index finger numbness, and non-radiating low back pain, as per QME report dated 03/03/15. The request is for RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION OF TRAMADOL 50 #60. There is no RFA for this case, and the patient's date of injury is 08/26/13. Diagnoses, as per QME report dated 03/03/15, included continuous trauma injury to the right knee with MRI showing tear of right medial meniscus, left shoulder sprain/strain, lumbosacral sprain/strain, left elbow lateral epicondylitis, and right carpal tunnel syndrome. As per progress report dated 07/27/15 (after the UR denial date of 04/26/15), the lower back pain is rated at 5/10, the left shoulder pain is rated at 7/10, the right elbow pain is rated at 7-8/10, and right knee pain is rated at 7/10. Medications included Flurbi (NAP) cream. The patient is working, as per QME report dated 03/03/15. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS p77 states, "Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." In this case, a prescription of Tramadol is first noted in progress report dated 02/19/14. It is not clear when this medication was initiated and if the patient has been using the opioid consistently since then or not. The treater does not use a pain scale to demonstrate reduction of pain nor does the treater provide specific examples that indicate improvement in function. No recent UDS and CURES reports are available for review. There is no discussion regarding side effects of Tramadol as well. MTUS requires a clear documentation regarding impact of Tramadol on 4As, including analgesia, ADLs, adverse side effects, and aberrant behavior, for continued opioid use. Additionally, MTUS p80, 81 states regarding chronic low back pain: "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." Long-term use of opiates may be indicated for nociceptive pain as it is "Recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury with the most common example being pain secondary to cancer)." However, this patient does not present with pain that is "presumed to be maintained by continual injury." Hence, the request IS NOT medically necessary.

Retrospective request for 1 IF unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: The 56-year-old patient complains of right knee pain, left shoulder pain, right elbow pain radiating to the right wrist with right thumb and index finger numbness, and non-radiating low back pain, as per QME report dated 03/03/15. The request is for RETROSPECTIVE REQUEST FOR IF UNIT. There is no RFA for this case, and the

patient's date of injury is 08/26/13. Diagnoses, as per QME report dated 03/03/15, included continuous trauma injury to the right knee with MRI showing tear of right medial meniscus, left shoulder sprain/strain, lumbosacral sprain/strain, left elbow lateral epicondylitis, and right carpal tunnel syndrome. As per progress report dated 07/27/15 (after the UR denial date of 04/26/15), the lower back pain is rated at 5/10, the left shoulder pain is rated at 7/10, the right elbow pain is rated at 7-8/10, and right knee pain is rated at 7/10. Medications included Flurbi (NAP) cream. The patient is working, as per QME report dated 03/03/15. MTUS pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." In this case, none of the progress reports discuss the request. The QME report, dated 03/03/15, states that the patient's future medical care should include shoulder and knee arthroscopic surgeries. In progress report dated 04/29/15 (after the UR denial date), the treater recommends surgical consultation for the left knee and states that patient will require DME for the procedure. As per progress report dated 06/19/15 (after the UR denial date), the patient is pending right knee arthroscopic surgery. However, there is no further discussion in this regard. It is not clear how and where this IF unit will be used. It is not clear if this request is for a rental or a purchase. The reports do not mention if the patient has completed the one-month trial or not. There is no indication of substance abuse. Given the lack of relevant documentation, the request IS NOT medically necessary.

Retrospective request for 1 cold therapy unit: 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), Shoulder (Acute & Chronic), Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter (acute & chronic) under 'Continuous-flow cryotherapy.

Decision rationale: The 56-year-old patient complains of right knee pain, left shoulder pain, right elbow pain radiating to the right wrist with right thumb and index finger numbness, and non-radiating low back pain, as per QME report dated 03/03/15. The request is for RETROSPECTIVE REQUEST FOR 1 COLD THERAPY UNIT. There is no RFA for this case, and the patient's date of injury is 08/26/13. Diagnoses, as per QME report dated 03/03/15, included continuous trauma injury to the right knee with MRI showing tear of right medial meniscus, left shoulder sprain/strain, lumbosacral sprain/strain, left elbow lateral epicondylitis,

and right carpal tunnel syndrome. As per progress report dated 07/27/15 (after the UR denial date of 04/26/15), the lower back pain is rated at 5/10, the left shoulder pain is rated at 7/10, the right elbow pain is rated at 7-8/10, and right knee pain is rated at 7/10. Medications included Flurbi (NAP) cream. The patient is working, as per QME report dated 03/03/15. ODG guidelines, chapter Knee (acute & chronic) under 'Continuous-flow cryotherapy', state the following: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In this case, none of the progress reports available for review discusses this request. The QME report, dated 03/03/15, states that the patient's future medical care should include shoulder and knee arthroscopic surgeries. In progress report dated 04/29/15 (after the UR denial date), the treater recommends surgical consultation for the left knee and states that patient will require DME for the procedure. As per progress report dated 06/19/15 (after the UR denial date), the patient is pending right knee arthroscopic surgery. However, there is no further discussion in this regard. It is not clear how and where this cold therapy unit will be used. Additionally, it is not known whether the request is for purchase or rental. The treater does not document the duration of treatment as well. Given the lack of relevant documentation, the request IS NOT medically necessary.

Retrospective request for 1 EMG/NCV studies of the upper and lower extremities (completed 9/25/13): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178, 261, 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: The 56-year-old patient complains of right knee pain, left shoulder pain, right elbow pain radiating to the right wrist with right thumb and index finger numbness, and non-radiating low back pain, as per QME report dated 03/03/15. The request is for 1 EMG/NCV STUDIES OF THE UPPER AND LOWER EXTREMITIES (COMPLETED 9/25/13). There is no RFA for this case, and the patient's date of injury is 08/26/13. Diagnoses, as per QME report dated 03/03/15, included continuous trauma injury to the right knee with MRI showing tear of right medial meniscus, left shoulder sprain/strain, lumbosacral sprain/strain, left elbow lateral epicondylitis, and right carpal tunnel syndrome. As per progress report dated 07/27/15 (after the UR denial date of 04/26/15), the lower back pain is rated at 5/10, the left shoulder pain is rated at 7/10, the right elbow pain is rated at 7-8/10, and right knee pain is rated at 7/10. Medications included Flurbi (NAP) cream. The patient is working, as per QME report dated 03/03/15. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electro diagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." ACOEM, chapter 12, page 303, Low Back Complaints states that EMG is supported by ACOEM for low back pain. NCV is not supported unless the patient has peripheral symptoms with suspicion for

peripheral neuropathy. ODG Guidelines, chapter Low Back-Lumbar & Thoracic (Acute & Chronic) chapter under EMGs (electromyography) states the following: Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS)', states that NCV studies are "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms based on radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy." In this case, none of the progress reports discusses the request. A review of the available progress reports indicates that patient underwent electro diagnostic studies for the upper extremities on 09/25/13, which was normal. The patient also underwent electro diagnostic studies for the lower extremities on 01/06/14, which revealed significant lumbar paraspinal muscle spasms and lumbar nerve roots irritation/traction injury, as per progress report dated 09/26/14. It is not clear why the treater is requesting for repeat EMG/NCV. The patient does suffer from right elbow pain radiating to the right wrist with right thumb and index finger numbness. However, there is no radiating pain in the lower extremities. ACOEM allows for repeat electro diagnostic studies only if the prior ones are negative during the acute phase. There is no new injury, new clinical information or change in neurologic findings to warrant updated studies. Hence, the request for EMG/NCV of bilateral upper and lower extremities IS NOT medically necessary.