

<b>Case Number:</b>	CM13-0011320		
<b>Date Assigned:</b>	09/20/2013	<b>Date of Injury:</b>	06/04/2010
<b>Decision Date:</b>	02/11/2014	<b>UR Denial Date:</b>	08/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Sports Medicine, and is licensed to practice in New York and Texas. 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 physician 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 57-year-old male who reported an injury on 06/04/2010. The mechanism of injury was stated to be the patient was assaulted at work. The patient was noted to have a complaint of upper back pain, bilateral shoulder pain, and neck pain. The patient's failed medications were noted to be Vicodin and morphine which made him nauseous. The patient was noted to have 2 large painful trigger points at C4-T1 dermatomal levels. The patient's range of motion was noted to be extremely limited. The patient's diagnosis was noted to be cervical radiculopathy, neck pain, left shoulder impingement syndrome status post surgery, bilateral shoulder pain, chronic pain syndrome, and myofascial syndrome. The request was made for a DNA saliva test, a Depo Medrol shoulder injection, and various medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 One-time saliva DNA test between 6/19/2013 and 9/24/2013: 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), Pain Chapter, Genetic Testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**Decision rationale:** The Official Disability Guidelines do not recommend genetic testing for potential opioid abuse. Clinical documentation submitted for review indicated the physician was ordering the 1 time saliva DNA test to assess the employee's predisposition to prescription narcotic dependence and/or tolerance. However, there is a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The employee was noted to be on opioid therapy. There is a lack of documentation indicating the employee had previous opioid testing that demonstrated non-compliance. Given the above and the lack of documentation of exceptional factors, the request for 1 one-time saliva DNA test between 6/19/2013 and 9/24/2013 is not medically necessary.

**1 Left shoulder Depo-Medrol injection between 6/19/2013 and 9/24/2013: 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), Section Pain (Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

**Decision rationale:** The ACOEM guidelines recommend subacromial injections for subacute and chronic rotator cuff tears and impingement syndrome. The clinical documentation submitted for review indicated that over the past 3 to 4 months the employee's pain and weakness in the arms has significantly increased and the employee indicated they cannot seem to use their arms any more. The physical examination revealed the range of motion was significantly limited on the left with discomfort with all movements with abduction, internal and external rotation being the worst. There was noted to be posterior tenderness over the left shoulder joint. Per the treatment plan, RFA page number 2, the physician requested authorization for a left shoulder Depo Medrol injection with MUA x1 then re-evaluation. However, there is a lack of documentation indicating the employee had the above conditions. Additionally, per the DWC RFA Form, the request was for a left shoulder Depo Medrol injection with MUA. Given the lack of clarity and the lack of documentation indicating the necessity, the request as submitted, for 1 left shoulder Depo-Medrol injection between 6/19/2013 and 9/24/2013 is not medically necessary.

**1 Prescription of Fluriflex 180gm between 6/19/2013 and 9/24/2013: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Topical Analgesics..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Sections Flurbiprofen, Topical Analgesics, Cyclobenzaprine Page(s): 72, 111 and 41.

**Decision rationale:** Flurbiprofen is classified as a non-steroidal anti-inflammatory agent. The MTUS guidelines indicate topical analgesics are "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....Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." This agent is not currently FDA approved for a topical application. FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine - National Institute of Health (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration... California MTUS Guidelines do not recommend the topical use of Cyclobenzaprine as a topical muscle relaxant as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine to other agents is not recommended." The clinical documentation submitted for review failed to provide exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for 1 prescription of Fluriflex 180gm between 6/19/2013 and 9/24/2013 is not medically necessary.

**1 Prescription of Nucynta 75mg #45 between 6/19/2013 and 9/24/2013: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids, criteria for use..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain, Page(s): 80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** The MTUS guidelines support the use of opioids for chronic back pain and indicates that a failure to respond to a time limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. The clinical documentation submitted for review indicated that the employee had taken Vicodin and morphine for the current condition and was unable to use these medications due to the side effect of nausea and tramadol was discontinued as well as it was not helpful. These medications are in the opioid family and as there was a failure of opioid medications, there was a lack of documentation indicating the rationale for another medication from the opioid family. Given the above, the request for 1 prescription of Nucynta 75mg #45 between 6/19/2013 and 9/24/2013 is not medically necessary.

**1 Prescription of Cidaflex #90 between 6/19/2013 and 9/24/2013: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Glucosamine (and Chondroitin Sulfate)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Chondroitin Sulfate/Glucosamine Hydrochloride Page(s): 50.

**Decision rationale:** The MTUS guidelines do not recommend Cidaflex, which is a combination of Chondroitin Sulfate/Glucosamine Hydrochloride for treatment of the knee in patients with moderate arthritis pain. The clinical documentation submitted for review failed to provide exceptional factors to warrant nonadherence to guideline recommendations and it failed to

indicate the efficacy of the requested medication. Given the above, the request for 1 prescription of Cidaflex #90 between 6/19/2013 and 9/24/2013 is not medically necessary.

**1 Prescription of Prilosec 20mg #30 between 6/19/2013 and 9/24/2013: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section NSAIDs: GI symptoms and cardiovascular risk factors..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section NSAIDs Page(s): 69.

**Decision rationale:** The MTUS guidelines recommend proton pump inhibitors (PPIs) for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide the employee had signs and symptoms of dyspepsia. It was indicated this medication was being request for acid reflux and GI upset. However, given the lack of documentation of signs and symptoms of the above, the request for 1 prescription of Prilosec 20mg #30 between 6/19/2013 and 9/24/2013 is not medically necessary.