

<b>Case Number:</b>	CM13-0012146		
<b>Date Assigned:</b>	09/08/2014	<b>Date of Injury:</b>	04/21/2011
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	07/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/16/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/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 injured worker is a 62-year-old female who reported an injury on 08/21/2011. The mechanism of injury was not submitted for review. The injured worker has diagnosis of cervical spine sprain/strain, bursitis, complete rupture of the rotator cuff of the right shoulder, right shoulder impingement syndrome and lumbar spine sprain/strain. Physical medical treatment consists of physical therapy, psychological evaluations, surgery, and medication therapy. Medications include Prozac, Ativan, Xanax, Wellbutrin, Fioricet, Omeprazole, and topical creams. The injured worker has undergone x-rays and MRI of the right shoulder. On 05/01/2013, the injured worker complained of neck, back, and shoulder pain. Examination of the extremities revealed there was no cyanosis, peripheral edema, or clubbing. There was no evidence of insufficiency or skin changes. Cranial nerves were intact. Gait was normal with ataxia. Deep tendon reflexes were normal. Babinski was down going. The treatment plan was for the injured worker to continue the use of medication therapy and also to receive a Functional Capacity Evaluation. The rationale and request for authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**APAP/Butalbital/CAP 325-50-40mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Fioricet Page(s): 23.

**Decision rationale:** The California MTUS Guidelines do not recommend the use of Fioricet for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. There is a risk of medication overuse as well as rebound headache. The request as submitted did not indicate a frequency or duration of the medication. Given the above, the request of APAP/Butalbital/CAP 325-50-40mg #120 is not medically necessary and appropriate.

**CAPS (5+) MENT/CAMP/Hyaluronic cream 0.05% #120:** 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 Topical Analgesics Page(s): 111.

**Decision rationale:** The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The submitted documentation did not indicate that the injured worker had any neuropathic pain. Furthermore, it was not indicated in the submitted reports that the injured worker had trialed and failed any antidepressant or anticonvulsants. Additionally, the request as submitted did not indicate where the medication would be applied. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request of CAPS (5+) MENT/CAMP/Hyaluronic cream 0.05% #120 is not medically necessary and appropriate.

**Keto Lidocaine cream #120:** 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 Topical Analgesics Page(s): 111-113.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Keto lido is a compound that contains Lidocaine and Ketoprofen. Lidocaine is not recommended per the MTUS guidelines. Guidelines also state that Ketoprofen is not currently FDA approved for a topical application. In addition, guidelines state that there is no evidence for use of any other

muscle relaxant as a topical product. Furthermore, submitted report did not provide the rationale as to why the injured worker would require a topical cream versus an oral medication. The request as submitted did not indicate the dosage, frequency, or duration of the medication. There was also no indication as to where the cream would be applied. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request of Keto Lidocaine cream #120 is not medically necessary and appropriate.

**Omeprazole 20mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

**Decision rationale:** The California MTUS Chronic Pain Guidelines state that proton pump inhibitors may be recommended to treat dyspepsia secondary to NSAID therapy. The addition of a proton pump inhibitor is also supported for patients taking NSAID medication who have cardiovascular disease or significant risk factors for gastrointestinal events. The injured worker was noted to be taking NSAIDs since at least 01/12/2013. However, there was no documentation indicating that the injured worker had complaints of dyspepsia with the use of medication, cardiovascular disease, or significant risk factors for gastrointestinal events. In the absence of this documentation, the request is not supported by the evidence based guidelines. Additionally, the request as submitted did not indicate a frequency or duration. As such, the request for Omeprazole 20mg #60 is not medically necessary and appropriate.

**Functional Capacity Evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, page 137-138.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional Capacity Evaluation.

**Decision rationale:** The California MTUS/ACOEM Guidelines state that a Functional Capacity Evaluation may be necessary to obtain a more precise delineation of the injured worker's capabilities. The Official Disability Guidelines further state that a Functional Capacity Evaluation is recommended and may be used prior to admission to a work hardening program with preference for assessment and tailored to a specific job or task. Functional Capacity Evaluations are not recommended for routine use. The submitted report lacked objective findings upon physical examination demonstrating significant functional deficit. Furthermore, there is lack of evidence of how a Functional Capacity Evaluation would aid the provider in evolving treatment plans or goals for the injured worker. Additionally, there was lack of documentation of other treatments the injured worker underwent previously and the measurements of progress, as well as efficacy of the prior treatments. The submitted reports also

lacked any indication that the injured worker was going to be admitted to a work hardening program. Given the above, the injured worker is not within the MTUS/ACOEM or ODG criteria. As such, the request for Functional Capacity Evaluation is not medically necessary.