

<b>Case Number:</b>	CM13-0048299		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	07/15/2010
<b>Decision Date:</b>	03/06/2014	<b>UR Denial Date:</b>	10/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2013

### 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, and is licensed to practice in Illinois. 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 43-year-old female who reported injury on 07/15/2010. The mechanism of injury was not provided. The patient was noted to have right ankle pain, swelling, and pain increased with activity. The patient was noted to be undergoing ankle surgery, and the diagnosis was noted to be instability of the ankle right ankle and the request was made for postoperative DME cold therapy, electrical stimulation unit, urinalysis, Biotherm, Theraflex, and Dyotion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Urine drug screen panel:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**Decision rationale:** MTUS Chronic Pain Guidelines indicate that the use of urine drug screening is for patients with documented issue of abuse, addiction, or poor pain control. The clinical documentation submitted for review failed to indicate the patient had documented issues of abuse, addiction, or poor pain control. There was a lack of documentation indicating the

necessity for the requested service. Given the above, the request for Urine drug screen panel is not medically necessary.

**Biotherm 120mg 4oz bottle:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylates Page(s): 105.

**Decision rationale:** MTUS Chronic Pain Guidelines recommend topical salicylates for the treatment of pain. The clinical documentation submitted for review indicated that the patient was having right shoulder pain and topical salicylates are appropriate for treatment of pain. Given the above, the request for Bio therm 120mg 4oz bottle is medically necessary.

**Theraflex 180mg cream:** Upheld

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

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

**Decision rationale:** The MTUS Chronic Pain Guidelines indicate topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Flurbiprofen is classified as a non-steroidal anti-inflammatory agent and according to the MTUS Chronic Pain Guidelines is not currently FDA approved for a topical application. The MTUS Chronic Pain 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 non-adherence to guideline recommendations. Additionally, there was a lack of documentation indicating the patient had trialed antidepressants and anticonvulsants that had failed. The request, as submitted failed to indicate the quantity of medication being requested. Given the above, the request for Theraflex 180mg cream is not medically necessary.

**Dyotin 250mg capsules #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 16-19. Decision based on Non-MTUS Citation FDA.gov

**Decision rationale:** The MTUS Chronic Pain Guidelines indicate that Gabapentin is recommended for neuropathic pain. However, a thorough search of FDA.gov indicated there was no acceptable form of a 250 mg sustained release capsule. Additionally, there was a lack of objective documentation indicating the patient had neuropathic pain. Given the above, the request for Dyotion 250mg capsules #120 is not medically necessary.

**Interferential Stimulation Unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(s): 118.

**Decision rationale:** MTUS Chronic Pain Guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention and should be used with recommended treatments including work, and exercise. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant non-adherence to guideline recommendations. Additionally, there was a lack of documentation indicating the patient would be using the interferential current stimulation with an exercise program and the duration for the request was not submitted. Given the above, the request for Interferential stimulation unit is not medically necessary.

**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, 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, Ankle & Foot Chapter, Continuous Flow Cryotherapy.

**Decision rationale:** Official Disability Guidelines indicate that continuous flow cryotherapy is not recommended as the foot and ankle have not been fully evaluated in studies. There is a lack of documentation indicating the duration of care for the cold therapy unit. Given the above and the lack of documentation of exceptional factors, the request for Cold therapy unit is not medically necessary.

**Right shoulder consult:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

**Decision rationale:** ACOEM Guidelines indicate a surgical consult is appropriate for patients who have red flag conditions, activity limitation more than 4 months plus existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus the existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the long and short term from surgical repair. The clinical documentation submitted for review indicated the patient had persistent pain. However, there was a lack of documentation indicating the patient had documented conservative care as well as imaging studies to support the necessity for the request. Given the above, the request for Right shoulder consult is not medically necessary.