

Case Number:	CM13-0059584		
Date Assigned:	12/30/2013	Date of Injury:	10/02/2009
Decision Date:	05/06/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	12/02/2013

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 Internal Medicine, has a subspecialty in Pulmonary Diseases 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 53-year-old female who reported an injury on 10/02/2009. The mechanism of injury was not provided. The documentation of 10/11/2013 revealed that the injured worker had complaints of ongoing aching and burning pain to her neck, upper back and right shoulder. It was indicated that a urine specimen was obtained to monitor medication use. The injured worker's medication was noted to be Advil. Diagnoses included a C5-6 disc herniation with right upper extremity radiculopathy, bilateral upper extremity overuse tendinopathy, right shoulder impingement syndrome and an L4-5 disc protrusion with right-sided radiculopathy. The treatment plan included chiropractic care. It was indicated that the injured worker had benefit with chiropractic care in the past. Additionally, it was requested that as the injured worker was unable to oral medications due to gastrointestinal effects, topical creams were the only recourse, and it was indicated that the injured worker needed refills fo the topical creams as the oral medications were causing stomach issues.

IMR ISSUES, DECISIONS AND RATIONALES

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

URINALYSIS (RETROSPECTIVE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Testing (UDT).

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

Decision rationale: The California MTUS Guidelines recommend urine drug screening for patients with documented issues of abuse, addiction or poor pain control. The clinical documentation submitted for review indicated that the injured worker had undergone a urine drug screen in 05/2013 and 07/2013. There was a lack of documentation indicating that the injured worker had documented issues of abuse, addiction or poor pain control. Additionally, the only medication that was reported as being used was Advil. Given the above, the request for a retrospective urinalysis is not medically necessary.

FLURIFLEX CREAM 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 Guidelines, Flurbiprofen; Topical Analgesics; Cyclobenzaprine Page(s): 72, 111 and 41.

Decision rationale: California MTUS indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are 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. 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 indicated that this request was a refill. However, there was a lack of documentation indicating the duration that the injured worker had been on the medication. Additionally, there was a lack of documentation of the efficacy of the requested medication. Given the above, the request for Flurflex cream 180 gm is not medically necessary.

TGICE CREAM 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 Tramadol; Topical Salicylates; Topical Analgesics; Gabapentin Page(s): 82;105;111;113.

Decision rationale: The California MTUS indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not

recommended is not recommended. Topical use of gabapentin is not recommended. There is no peer-reviewed literature to support use. The addition of cyclobenzaprine to other agents is not recommended. The clinical documentation submitted for review indicated that this request was a refill. However, there was a lack of documentation indicating the duration that the injured worker had been on the medication. Additionally, there was a lack of documentation of the efficacy of the requested medication. Given the above, the request for TGICE cream 180 gm is not medically necessary.

CHIROPRACTIC THERAPY FOR THE RIGHT SHOULDER AND CERVICAL SPINE, TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, Manipulation.

Decision rationale: The California MTUS Guidelines recommend manual therapy for chronic pain if caused by musculoskeletal conditions. They do not, however, address manual therapy for the shoulder or cervical spine. As such, secondary guidelines were sought. The ODG indicate that the appropriate treatment for sprains/strains of the shoulder and upper arm is 9 visits. The appropriate number of visits for regional neck pain is 9 visits. However, the clinical documentation submitted for review indicated that the injured worker had previously attended chiropractic care. There was a lack of documentation of objective functional benefit received from the prior chiropractic treatments. Given the above, the request for chiropractic therapy for the right shoulder and cervical spine at 2 times a week for 4 weeks is not medically necessary.