

<b>Case Number:</b>	CM14-0172707		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	05/20/2011
<b>Decision Date:</b>	12/02/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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 Occupational Medicine 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:

Injured worker is a female with date of injury 5/20/2011. Per primary treating physician's progress report dated 2/20/2014, the injured worker is having an acute exacerbation of her neck and right shoulder pain. She would like to get chiropractic care. Based on the provision of future medical care as outlined by the agreed medical evaluator, she does have future medical care to include therapy. On examination the right anterior shoulder is tender to palpation. The lateral aspect of the right elbow is tender to palpation. Sensation is reduced in right median nerve distribution at the right wrist. Right grip strength is reduced. Diagnoses include; right shoulder internal derangement, right lateral epicondylitis and right wrist sprain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Twelve (12) chiropractic therapy sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chiropractic Guidelines, Shoulder (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation section Page(s): 58-61.

**Decision rationale:** Per the MTUS Guidelines, chiropractic care consisting of manual therapy and manipulation for the low back is recommended for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. A therapeutic trial of 6 visits over 2 weeks is recommended. If there is evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks are recommended. Elective or maintenance care is not recommended. Recurrences or flare ups should be evaluated for treatment success, and if return to work is achieved, 1-2 visits every 4-6 months are reasonable. The requesting physician explains that this request is for 12 visits of chiropractic care with massage for the neck, right shoulder, right wrist and right upper extremity at a frequency of one time per week for 12 weeks. There is no report of prior chiropractic therapy, or efficacy of such treatments. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. Therefore, the requested twelve (12) chiropractic therapy sessions are not medically necessary and appropriate.

**One (1) large ice pack with cloth:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 173-174, 203.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 17, 174.

**Decision rationale:** Per the MTUS Guidelines, there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living. Therefore, the request for One (1) large ice pack with cloth is not medically necessary and appropriate.

**Omeprazole DR 20mg #90 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk section Page(s): 68, 69.

**Decision rationale:** Proton pump inhibitors, such as omeprazole are recommended when using NSAIDs if there is a risk for gastrointestinal events. There is no indication that the injured worker has had a gastrointestinal event or is at increased risk of a gastrointestinal event, which may necessitate the use of omeprazole when using NSAIDs. The injured worker is noted to be under 65 years old, and there are no risk factors reported in the medical reports for GI events

with the use of NSAIDs. Therefore, the Omeprazole DR 20mg #90 with 2 refills is not medically necessary and appropriate.

**Medrox pain relief ointment, 240gm with 2 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Topical, Salicylate Topicals, NSAIDs, Menthol.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin Topical section, Topical Analgesics section Page(s): 28, 29, 111-113.

**Decision rationale:** Medrox patch is a topical analgesic containing the active ingredients methyl salicylate 5%, menthol 5% and capsaicin 0.0375%. The requesting physician explains that the injured worker has used Medrox ointment previously; however, there is no explanation of efficacy or side effects from the use of this medication. The MTUS Guidelines recommend the use of topical analgesics as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The MTUS Guidelines do recommend the use of topical capsaicin only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there are no current indications that this increase over a 0.025% formulation would provide any further efficacy. Since capsaicin 0.0375% is not recommended by the MTUS Guidelines, the use of Medrox Patch is not recommended. Therefore, Medrox ointment, 240gm with 2 refills is not medically necessary and appropriate.

**Ketoprofen 75mg #90 with 2 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs section Page(s): 67-71.

**Decision rationale:** The use of NSAIDs is recommended by the MTUS Guidelines with precautions. NSAIDs are recommended to be used secondary to acetaminophen, and at the lowest dose possible for the shortest period in the treatment of acute pain or acute exacerbation of chronic pain as there are risks associated with NSAIDs and the use of NSAIDs may inhibit the healing process. The injured worker has chronic injuries with recent acute exacerbation, however, three months of medication appears to be for chronic treatment, not short term treatment for an acute exacerbation. As such, Ketoprofen 75mg #90 with 2 refills is not medically necessary and appropriate.

**Orphenadrine ER 100mg #180 with 2 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) section, Weaning of Medications section Page(s): 63-65, 124.

**Decision rationale:** Non-sedating muscle relaxants (for pain) are recommended by the MTUS Guidelines with caution for short periods for treatment of acute exacerbations of chronic low back pain, but not for chronic or extended use. In most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Norflex is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to antalgic and anticholinergic properties. Therefore, Orphenadrine ER 100mg #180 with 2 refills is determined to not be medically necessary.