

<b>Case Number:</b>	CM14-0022564		
<b>Date Assigned:</b>	05/12/2014	<b>Date of Injury:</b>	03/20/2007
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	01/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 51-year-old female who reported an injury on 03/20/2007 due to unknown mechanism. The injured worker complained of neck pain with dullness rated at 7/10, right shoulder pain rated at 8/10 but is constant with burning right lower extremity; chest pain is at 7/10, which is causative by the shoulder. Physical examination dated 01/08/2014, was tenderness to the cervical spine with diffuse pain to the left shoulder. On objective findings, there was a review data of a magnetic resonance imaging (MRI) date unknown of the left shoulder, which revealed acromion flat laterally down-sloping, acromioclavicular (AC) joint osteoarthritis, and tendinosis of the supraspinatus. The injured worker's diagnoses are cervical herniated nucleus polyposis' 2 to 3 mm, myospasms, left shoulder pain, and tendinosis. The injured worker's medication was not submitted with documentation. The injured worker's past treatments and diagnostics were an upper extremity electrotomography dated 01/22/2014. Impression of study was electrotomographic evidence suggestive of muscle membrane irritability in the left deltoid muscle. The muscle membrane irritability is nonspecific finding that can be seen in both neuropathic and myopathic process. The injured worker also had a Functional Capacity Evaluation done. Request for authorization and rationale was not provided with documentation submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**URINALYSIS TEST FOR TOXICOLOGY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines URINE DRUG SCREENING. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Pain Procedure Summary (last updated 01/07/14), Urine Drug Testing.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

**Decision rationale:** The request for urinalysis test for toxicology is not medically necessary. Drug testing, according to the California Medical Treatment Utilization Schedule, recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs, or steps to take before a therapeutic trial of opioids. Guidelines indicate that drug testing can be a diagnostic tool for on-going management opioids, and opioids screening for risk of addiction. In the absence of further documentation indicating the injured worker's current medications, previous urine drug screen results, and risk of aberrant behavior assessment and pain assessment, the request for urinalysis test for toxicology is not medically necessary.

**PAIN MANAGEMENT REFERRAL:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Neck and Upper Back, Procedure Summary (last updated 12/16/2013), Office Visits.

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

**Decision rationale:** The request for pain management referral is medically necessary. The California MTUS recommended as determined to be medically necessary. Evaluation and management outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The injured worker complained of neck pain rated at 7/10 with bilateral upper extremities involvement. Pain characteristics described as constant. The Primary Treating Physician's Progress Report notes the injured worker complained of pain on several clinical visits. In addition, there was no decrease in pain documented on clinical visits subjectively or objectively, with medication, or chiropractic treatment. As such, the request for pain management referral is medically necessary.

**TOPICAL COMPOUND CREAMS:**

**FLURIBIPROFEN/CAPSAICIN/MENTHOL/CAMPBOR:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The request for topical compound creams flurbiprofen/capsaicin/menthol/camphor is not medically necessary. According to 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. 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 then the topical cream itself is not recommended. The proposed topical analgesic compound contains capsaicin. There is no current indication that capsaicin would provide any further efficacies. The guidelines also state that capsaicin has had positive affects in patients with osteoarthritis, fibromyalgia, and chronic nonspecific back pain, but it is highly experimental in high doses. The request does not specify the location for the application of the proposed cream. The injured worker had neck and bilateral upper extremities pain complaints. The injured worker's diagnoses were cervical herniated nucleus pulposus 2 to 3 cm, myospasms, left shoulder pain, and tendinosis. There was no supporting documentation of fibromyalgia or osteoarthritis. In addition the request lack of frequency and body location for application of the proposed topical cream. Given the above, the request is not medically necessary.

**TOPICAL COMPOUND CREAM:  
KETOPROFEN/CYCLOBENZAPRINE/LIDOCAINE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic, NSAIDS Page(s): 111-112.

**Decision rationale:** The request for topical compound cream ketoprofen/cyclobenzaprine/lidocaine is not medically necessary. The California MTUS guidelines state that topical creams 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 analgesics are applied to painful areas, however the proposed topical cream is a compound, and are not recommended if the compound contain at least one of the drugs that is not recommended. Cyclobenzaprine is classified as a muscle relaxant and there is no evidence for use of any muscle relaxant as a topical product. Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first line therapy such as antiepileptic drugs like gabapentin or Lyrica. Topical lidocaine in the formulation of a dermal patch, Lidoderm, has been designated for orphan status by the Food and Drug Administration for neuropathic pain. No other commercially approved topical formulation of lidocaine is indicated for neuropathic pain. The treating physician noted in clinical documentation that the injured worker had tenderness to the cervical area with diffuse pain to the left shoulder. In addition, the request does not specify the location for application of the proposed cream. Furthermore, the request does not include the frequency for the proposed medication. Given the above, the request is not medically necessary.

**FOLLOW UP IN 4 WEEKS:** 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-TWC), Pain Procedure Summary (last updated 01/07/2014), Office Visits.

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

**Decision rationale:** The request for follow-up in 4 weeks is not medically necessary. The Official Disability Guidelines state that office visits are recommended as determined to be medically necessary. Evaluation and management outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The initial pain management referral was certified, however, in the absence of documentation, rationale and what type of follow-up in 4 weeks is not supported by guidelines. The request is not medically necessary.