

<b>Case Number:</b>	CM14-0058887		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	09/25/2012
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	04/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2014

### 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 Orthopedic Surgery 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:

This 44-year-old female office manager sustained an industrial injury on 9/25/12, relative to repetitive work duties. The 3/18/14 treating physician progress report cited increased spasms and swelling of the right thumb, right shoulder, and neck without therapy. Difficulty sleeping was reported due to pain. Pain was worse with pushing, pulling, neck bending, light lifting, and reaching. Objective findings documented tenderness to the C3-C7 region, right paraspinals, and right acromioclavicular joint and subacromial bursa with decreased range of motion. The diagnosis was cervical disc and radiculopathy, right shoulder tendinosis, and thoracic sprain/strain. The treatment plan recommended authorization for FCMC and Keto creams, orthopedic surgical consult and drug screening. The patient was off work. The 3/18/14 pain management report cited constant cervicothoracic and arm pain, and low back pain radiating to the gluteal region. Medications were barely helping. Objective findings documented limited and painful cervical range of motion, 4/5 right upper extremity strength, diminished right upper extremity deep tendon reflexes, and decreased right C5-C7 dermatomal sensation. MRI findings were positive for C5/6 and C6/7 disc protrusions with EMG findings of chronic right C6 and C7 radiculopathy. The treatment plan recommended a cervical epidural steroid injection. The 4/4/14 utilization review denied the requests for FCMC and Keto creams, orthopedic consult and urine toxicology screen. The requests for topical creams were denied based on an absence of guideline support. The request for orthopedic surgical consult was based on failure to meet guideline criteria for surgical consultation. The request for urine toxicology screen was denied based on no documentation of on-going opioid therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FCMC Cream, quantity unspecified.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Medical Treatment Guidelines Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** The California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical agents are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for FCMC cream is poorly defined with no indication as to the specific compounded drugs. As not all compounded agents can be recommended, this request for FCMC cream, quantity unspecified is not medically necessary.

**Keto Cream, quantity unspecified.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Medical Treatment Guidelines Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** The California MTUS indicates that Ketoprofen is not currently FDA approved for a topical application and has an extremely high incidence of photo contact dermatitis. Guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Given the absence of guideline support for the topical use of Ketoprofen, this request for Keto cream, quantity unspecified, is not medically necessary.

**Orthopedic Surgical Consultation for the Cervical Spine, Thoracic Spine and Right Shoulder:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180, 209.

**Decision rationale:** The California MTUS guidelines state that referral for surgical consultation for the cervical spine is indicated for patients who have persistent, severe, and disabling shoulder or arm symptoms with activity limitation for more than one month or with extreme progression

of symptoms. Guidelines require documented failure of conservative treatment to resolve radicular symptoms and clear clinical, imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short- and long-term. Shoulder referral criteria also require clear evidence of a surgical lesion and failure of a range of motion and strengthening program. Guideline criteria have been met for the cervical spine, thoracic and right shoulder. This patient presents with increased cervical and radicular arm symptoms that have worsened and failed to respond to conservative treatment. Imaging and electrodiagnostic findings are consistent with exam findings of cervical radiculopathy. There is persistent AC joint tenderness and paraspinal pain and tenderness. Therefore, this request for orthopedic surgical consultation for the cervical spine, thoracic spine and right shoulder is medically necessary.

**Urine Toxicology Screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines Page(s): 43, 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Urine drug testing (UDT).

**Decision rationale:** The California Medical Treatment Utilization Schedule supports the use of drug screening in patients using opioid medication with issues of abuse, addiction, or poor pain control. The Official Disability Guidelines provide specific indications for urine drug testing. Ongoing monitoring is supported if the patient has evidence of high risk of addiction, history of aberrant behavior, history of addiction, or for evaluation of medication compliance and adherence. It is currently recommended that patients at low risk for adverse outcomes be monitored randomly approximately every 6 months. Guidelines state that those patients at high risk of adverse outcomes may require testing as often as once a month. Guideline criteria have not been met. Records indicate that the patient underwent urine drug testing on 2/11/14 with no indication of non-compliance with medications. There is no documentation that this patient is at high risk of adverse outcomes to support the medical necessity of additional urine drug testing at this time. Therefore, this request for a urine toxicology screen is not medically necessary.