

Case Number:	CM15-0059061		
Date Assigned:	04/03/2015	Date of Injury:	08/05/2014
Decision Date:	05/27/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	03/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 32-year-old male, who sustained an industrial injury on 08/05/2014. The mechanism of injury was flipping a 60-80 pound chamber. He has reported subsequent right shoulder pain and was diagnosed with unspecified derangement of the shoulder and right rotator cuff sprain/strain. Treatment to date has included oral and topical pain medication, application of ice, physical therapy, acupuncture and manipulation. In a progress note dated 01/15/2015, objective findings were notable for positive impingement sign of the right shoulder. The remainder of the visit note is illegible. A request for authorization of 8 visits of acupuncture of the right shoulder, 4 visits of chiropractic manipulative treatment of the right shoulder, drug screen qualitative single drug class method, Flurbiprofen and Ketoprofen was made.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unlisted Acupuncture Procedure, right shoulder Qty 8.00: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and it is recommended as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The time to produce functional improvement is 3-6 treatments and Acupuncture treatments may be extended if functional improvement is documented including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. The clinical documentation submitted for review indicated the injured worker had previously undergone acupuncture. There was a lack of documentation of a clinically significant improvement in activities of daily living or reduction in work restrictions. There was a lack of documentation that pain medication had been reduced or not tolerated. The quantity of sessions previously attended was not provided. Given the above, the request for unlisted acupuncture procedure, right shoulder qty 8.00 is not medically necessary.

Chiropractic Manipulative treatment right shoulder Qty 4.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58, 59.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement, a total of up to 18 visits over 6-8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle & foot, carpal tunnel syndrome, the forearm, wrist, & hand or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4-6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks and at 8 weeks patients should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. The clinical documentation submitted for review indicated the injured worker had previously undergone chiropractic treatments. There was as lack of documentation of an improvement in function, decreased pain, and improvement in quality of life. The quantity of sessions was not provided. Given the above, the request for chiropractic manipulative treatment right shoulder Qty 4.00 is not medically necessary.

Drug Screen qualitative single drug class method: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Screen Page(s): 77.

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

Decision rationale: The California MTUS indicates that the use of urine drug screening is for injured workers with documented issues of abuse, addiction, or poor pain control. The clinical documentation submitted for review failed to provide documentation that the injured worker had issues of abuse, addiction, or poor pain control. Given the above, the request for a Drug Screen qualitative single drug class method is not medically necessary.

Flurbiprofen 120gms, Qty 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain-topical analgesics-NSAIDS.

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

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety 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 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. A search of the National Library of Medicine - National Institute of Health (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration. The clinical documentation submitted for review failed to provide documentation of a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation indicating a necessity for two topical NSAIDs. The request as submitted failed to indicate the frequency and body part to be treated. Given the above, the request for flurbiprofen 120 gms, qty 1.00 is not medically necessary.

Ketoprofen 120gms Qty 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain-Topical analgesics Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Topical Ketoprofen Page(s): 111, 112.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. 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. Ketoprofen is not currently FDA approved for a topical application. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant non-adherence to guideline recommendations. There was a lack of documentation indicating the injured worker had a trial of failure of antidepressants and anticonvulsants. The request as submitted failed to indicate the frequency for the requested medication, as well as the body part to be treated. There was a lack of documentation indicating a necessity for two topical NSAIDs. Given the above, the request for ketoprofen 120 gms qty 1.00 is not medically necessary.