

<b>Case Number:</b>	CM14-0120302		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	03/05/2014
<b>Decision Date:</b>	12/19/2014	<b>UR Denial Date:</b>	07/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2014

### 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 Emergency 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:

The injured worker is 60 year old female with a date of injury as 03/05/2014. The worker was injured when she slipped and fell resulting in an injury to the left shoulder and right ankle. The current diagnoses are left shoulder front rotator cuff tear, frozen shoulder, and right ankle sprain/strain. Previous treatments include chiropractic treatment, multiple medications, and a Magnetic Resonance Imaging (MRI) of the left shoulder on 04/21/2014. Magnetic Resonance Imaging (MRI) revealed a full thickness tear of the supraspinatus tendon. A primary treating physicians report dated 07/30/2014 was included in the documentation submitted. Presenting complaints included left shoulder pain, constant aching and throbbing. Right ankle pain without changes, complaint of 5 out of 10 pain. The worker indicated that there was some relief of pain with chiropractic treatment. Physician report indicated that there was an improvement of function, but no detail of this improvement was provided. Physical examination revealed guarding of the ankle. The injured worker requested to return to work with restriction. The injured worker was placed on modified duty on 07/30/2014 with restrictions in overhead work and climbing. The physician recommended continued chiropractic treatment and was scheduled for an orthopedic consult. Other documentation submitted included chiropractic progress notes from 07/28/2014 through 08/07/2014, documentation supports that the injured worker completed 6 chiropractic treatments for the left shoulder. A request for authorization was made on 06/26/2014 for chiropractic treatment, 12 sessions to the left shoulder, Functional Capacity Evaluation Initial, Naproxen, and cyclo keto lido cream. The utilization review performed on 07/03/2014 non-certified a prescription for chiropractic treatment, 12 sessions to the left shoulder, Functional Capacity Evaluation Initial, Naproxen, and cyclo keto lido cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Capacity Evaluation (FCE): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81.

**Decision rationale:** As per ACOEM guidelines, determining limitations of work "is not really a medical issue" and that most assessing physicians should be able to determine limitations without additional complex testing modalities. As per ACOEM Chapter 1 Prevention, pg 12; "there is no good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints and injuries." While there may be occasional need for FCE, the treating physician has not documented why any work limitation assessment could not be done without a full FCE. The request for FCE is not medically necessary.

**Chiropractic Treatment Twelve (12) Sessions Left Shoulder: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-59.

**Decision rationale:** As per MTUS Chronic pain guidelines, manipulation is only recommended for low back issues. It is not recommended for the shoulder. The claimed "improvement" by the patient is subjective with no actual objective improvement documented. Chiropractic treatment of shoulder is not medically necessary.

**Naproxen 550 mg. #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs(Non-steroidal anti-inflammatory drugs) Page(s): 67.

**Decision rationale:** As per MTUS Chronic pain guidelines, NSAIDs are useful of osteoarthritis related pain. Due to side effects and risks of adverse reactions, MTUS recommends as low dose and short course as possible. There is no documentation of improvement with this medication. Patient is chronically on this medication on maximal dose. There is no plan to either taper or stop this medication. Chronic use without benefit is not recommended. Naproxen 550mg is not medically necessary.

**Cyclo/Keto/Lido Cream:** 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): 111-113.

**Decision rationale:** As per MTUS guidelines "Any compound product that contains a drug or drug class that is not recommended is not recommended." 1) Ketoprofen: Not FDA approved for topical applications. The use of a non-FDA approved application of a medication when there are multiple other topical NSAIDs is not medically necessary. Not recommended. 2) Cyclobenzaprine: Not recommended for topical application. 3) Lidocaine: Topical lidocaine is recommended for post-herpetic neuralgia only although it may be considered as off-label use as a second line agent for peripheral neuropathic pain. It may be considered for peripheral neuropathic pain only after a trial of 1st line agent. Patient has no neuropathic related pathology. Not recommended. Not a single component is recommended. Cyclo/Keto/Lido cream is not medically necessary.