

<b>Case Number:</b>	CM14-0124996		
<b>Date Assigned:</b>	08/11/2014	<b>Date of Injury:</b>	01/06/2014
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	07/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2014

### 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, and 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 53-year-old male who reported an injury on 01/06/2014. The diagnosis was lumbar sprain and strain. The mechanism of injury was the injured worker was lifting a box. The surgical history, medication, prior treatments and diagnostic studies were not provided. The office note of 06/20/2014 was handwritten and difficult to read. The subjective and objective complaints were difficult to read, as was the treatment plan. The requests were made per the submitted requests for acupuncture to the lumbar spine and right shoulder, chiropractic treatments, an MRI of the right shoulder, an MRI of the lumbar spine, compounded medications, and a referral to the general surgeon for a left inguinal hernia as well as a Functional Capacity Evaluation. There was a Request for Authorization for urine toxicology screen, but there was no Request for Authorization form for other requested services and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture (2 times a week for 6 weeks to the lumbar spine): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The California MTUS Guidelines indicate 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 to hasten functional recovery. The time to produce functional improvement is 3 to 6 treatments. The clinical documentation submitted for review was handwritten and illegible. The request for 12 visits would be excessive without re-evaluation after six treatments. Given the above, and the lack of legible documentation, the request is not medically necessary.

**Acupuncture (2 times a week for 6 weeks to the right shoulder): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines- Acupuncture Guidelines

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The California MTUS Guidelines indicate 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 to hasten functional recovery. The time to produce functional improvement is 3 to 6 treatments. The clinical documentation submitted for review was handwritten and illegible. The request for 12 visits would be excessive without re-evaluation after six treatments. Given the above, and the lack of legible documentation, the request is not medically necessary.

**Chiropractic treatment (2 times a week for 6 weeks to the lumbar spine): 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 MTUS Guidelines indicate that manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. The California MTUS Guidelines indicate that an initial therapeutic trial of 6 sessions is appropriate for treatment of the back. The request as submitted was for 12 sessions. The request for 12 visits would be excessive without re-evaluation after 6 treatments. There was no legible documentation requesting the services submitted for review. Given the above, the request is not medically necessary.

**Chiropractic treatment (2 times a week for 6 weeks to the right shoulder): 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 MTUS Guidelines indicate that manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. The California MTUS Guidelines indicate that an initial therapeutic trial of 6 sessions is appropriate for treatment of the back. The request as submitted was for 12 sessions. The request for 12 visits would be excessive without re-evaluation after 6 treatments. There was no legible documentation requesting the services submitted for review. Given the above, the request is not medically necessary.

**Functional Capacity Evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 137-138.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, FCE

**Decision rationale:** The American College of Occupational and Environmental Medicine Guidelines indicate there is a functional assessment tool available and that is a Functional Capacity Evaluation; however, it does not address the criteria. As such, secondary guidelines were sought. The Official Disability Guidelines indicates that a Functional Capacity Evaluation is appropriate when a worker has had prior unsuccessful attempts to return to work, has conflicting medical reports, the patient had an injury that required a detailed exploration of a workers abilities, a worker is close to maximum medical improvement and/or additional or secondary conditions have been clarified. The clinical documentation submitted for review failed to provide legible documentation to support the request. There was a lack of documentation indicating the injured worked had a failed attempt to return to work and that all secondary conditions had been clarified as it was indicated there was a request for both chiropractic and acupuncture for the shoulder and lumbar spine. Given the above, the request is not medically necessary.

**MRI of the right shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Shoulder MRI

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates that for most injured workers with shoulder problems, special studies are not needed unless a 4 to 6-week period of conservative care and observation fails to improve symptoms. There was no legible documentation submitted for review indicating the injured worker had exhausted and failed conservative care. Given the above, the request is not medically necessary.

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- MRI

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient to warrant imaging in injured workers who do not respond to treatment and who would consider surgery an option. There was no legible documentation submitted for review indicating the injured worker had exhausted and failed conservative care. Given the above, the request is not medically necessary.

**Urine Drug Screen:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Drug Testing

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

**Decision rationale:** The California MTUS Guidelines recommend urine drug screens for injured workers who have documented issues of abuse, addiction, or poor pain control. There was a lack of documentation indicating the medications the injured worker was utilizing to support the necessity for a urine drug screen. There was a lack of legible documentation indicating the injured worker had documented issues of abuse, addiction, or poor pain control. The request as submitted failed to indicate the quantity of urine drug screens being requested. Given the above, the request is not medically necessary.

**Referral to General Surgeon for Left Inguinal Hernia:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

**Decision rationale:** The California MTUS guidelines indicate that upon ruling out a potentially serious condition, conservative management is provided and if the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. There was a lack of legible documentation with examination findings to support the necessity for a referral to a general surgeon. Given the above, the request is not medically necessary.

**Compound Medication (Gabapentin 10%, Dextromethorphan 10%, and Amitriptyline 10%):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Compound Medications Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Antidepressants; Topical Gabapentin, does not address Dextromethorphan Page(. Decision based on Non-MTUS Citation Skolnick P (1999) Antidepressants for the new millennium. Eur J Pharmacol 375:31-40. <http://www.drugs.com/dextromethorphan.html>

**Decision rationale:** The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and 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. Gabapentin is not recommended for topical use as there is no peer-reviewed literature to support its' use. Peer reviewed literature states that while local peripheral administration of antidepressants has been demonstrated to produce analgesia in the formalin model of tonic pain; a number of actions, to include inhibition of noradrenaline (NA) and 5-HT reuptake, inhibition of NMDA, nicotinic, histamine, and 5-HT receptors, and block of ion channels and even combinations of these actions, may contribute to the local peripheral efficacy of antidepressant; therefore the contribution of these actions to analgesia by antidepressants, following either systemic or local administration, remains to be determined. Per Drugs.com "Dextromethorphan is a cough suppressant." There was a lack of legible documentation indicating the injured worker had neuropathic pain and that a trial of antidepressants and anticonvulsants had failed. There was a lack of documentation indicating the rationale for dextromethorphan in the topical cream. The request as submitted failed to indicate the frequency and quantity of medication being requested. The duration of use could not be established. Given the above, the request is not medically necessary.

**Compound Medication (Flurbiprofen 20%, Tramadol 20%, and Cyclobenzaprine 4%):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Compound Medications Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen; Topical analgesics; Cyclobenzaprine; Tramadol Page(s): 72; 111; 41; 82. Decision based on Non-MTUS Citation FDA.gov; National Library of Medicine - National Institute of Health (NLM-NIH)

**Decision rationale:** The California MTUS indicates 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. Guidelines also state that 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. Flurbiprofen is

classified as a non-steroidal anti-inflammatory agent. 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. A thorough search of FDA.gov, did not indicate there was a formulation of topical Tramadol that had been FDA approved. The approved form of Tramadol is for oral consumption, which is not recommended as a first line therapy. The guidelines do not recommend the topical use of Cyclobenzaprine as topical muscle relaxants as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine to other agents is not recommended. There was a lack of legible documentation indicating the injured worker had neuropathic pain and had trialed and failed antidepressants and anticonvulsants. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. The duration of use could not be established through supplied documentation. The request as submitted failed to indicate the frequency and quantity of the medication being requested. Given the above, the request is not medically necessary.