

Case Number:	CM13-0071219		
Date Assigned:	01/08/2014	Date of Injury:	04/11/2012
Decision Date:	03/16/2015	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	12/26/2013

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

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 38-year-old female who reported an injury on 04/11/2012. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of left shoulder impingement syndrome, left cubital tunnel syndrome, right carpal tunnel syndrome and entrapment bilateral wrists, left upper trapezius myofascial strain, and left biceps tendinitis. Past medical treatments consisted of E-stim therapy, ultrasound and medication therapy. Medications included Naprosyn. X-rays were obtained of the left shoulder which were normal. The most recent progress note submitted for review was dated 12/12/2012 which indicated the injured worker complained of left shoulder, left elbow, left wrist, and left hand pain. It was noted on physical examination that there was pain and tenderness along the injured worker's left shoulder. Muscle strength was 3/5 in the left shoulder. Medical treatment plan was for continued medication. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

UNKNOWN LABS WITH URINALYSIS (BETWEEN 10/23/13 AND 3/17/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines URINE DRUG SCREEN.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: LABS per labtestsonline.org

Decision rationale: The request for unknown labs with urinalysis between 10/23/2013 and 03/17/2014 was not medically necessary. [REDACTED] state that comprehensive metabolic panel (CMP) is used as a broad screening tool to evaluate organ function and check conditions such as diabetes, liver disease, and kidney disease. The CMP may also be ordered to monitor known conditions, such as hypertension, and to monitor people taking specific medications for any kidney or liver related side effects. If a doctor is interested in following 2 or more individual CMP components, they may order the entire CMP because it offers more information. The submitted documentation lacked any specification of labs that were obtained between 10/23/2013 and 03/17/2014. The results were not submitted for review. Additionally, there was no rationale submitted for review to warrant the request. Furthermore, the request as submitted indicated that the decision is for unknown labs with urinalysis between 10/23/2013 and 03/17/2014; no documentation was submitted for review between those dates. Given the above, the request would not have been indicated. As such, this request is not medically necessary.

1 ELECTROCARDIOGRAM (EKG) (BETWEEN 10/23/13 AND 3/17/14): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS)

Decision rationale: The request for 1 electrocardiogram between 10/23/2013 and 03/17/2014 is not medically necessary. The Official Disability Guidelines recommend electrodiagnostic testing depending on conditions and indications. Testing should be medically indicated. Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designated only for screening purposes rather than diagnosis are not acceptable. The submitted documentation did not indicate as to why the injured worker underwent an electrocardiogram, nor was there any indication the outcome of such testing. Additionally, there was no rationale submitted for review to warrant the request. Furthermore, the request as submitted is for an electrocardiogram between 10/23/2013 and 03/17/2014. There was no documentation submitted for review with those dates. Given the above, the request would not have been indicated. As such, this request is not medically necessary.

1 PRESCRIPTION OF MEDROX PATCHES (BETWEEN 10/23/13 AND 3/17/14): 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 Salicylate; Topical Analgesic; Topical Capsaicin Page(s): 105; 111; 28.

Decision rationale: The request for 1 prescription of Medrox patches between 10/23/2013 and 03/17/2014 is not medically necessary. The California MTUS indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety; they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended, is not recommended. Capsaicin is recommended only as an option in patients who have not responded to or are intolerant of other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there was no current indication that this increase over a 0.025% formulation would provide any further efficacy. Additionally, it indicates that topical salicylates are approved for chronic pain. According to the Medrox packet insert, Medrox is a topical analgesic containing menthol 5% and 0.0375% capsaicin and it is indicated for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, and muscle soreness and stiffness. Capsaicin, however, is not approved for topical application. The submitted documentation did not indicate the efficacy of the medication, nor was there any mention of the injured worker having any neuropathic pain. Furthermore, the request as submitted is for a prescription of Medrox between 10/23/2013 and 03/17/2014; however, the medical records submitted for review did not contain these dates. Given the above and the evidence based guidelines, the request would not be indicated. As such, this request is not medically necessary.

1 PRESCRIPTION FOR 240G OF TOPICAL OINTMENT (FLURBIPROFEN 20%/TRAMADOL 20% AND KETOPROFEN 20%/LIDOCAINE 10%/DEXAMETHASONE 4%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines COMPOUND TRANSDERMAL CREAM.

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

Decision rationale: The request for 1 prescription for 240 gm of topical ointment is not medically necessary. The California MTUS Guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended, is not recommended. Regarding the use of ketoprofen, this agent is not currently FDA approved for topical application. The California MTUS Guidelines also indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy to include tricyclics or SNRIs or an AED such as gabapentin or Lyrica. No other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Given the above guidelines, the request would not be indicated. Additionally, the submitted reports lacked any indication of the efficacy of the medication, nor did it indicate if it helped with any functional

deficits. Additionally, the request as submitted did not specify a dosage nor did it indicate or specify the location the cream would be administered. Given the above, the request is not medically necessary.