

<b>Case Number:</b>	CM15-0149915		
<b>Date Assigned:</b>	08/10/2015	<b>Date of Injury:</b>	03/30/2006
<b>Decision Date:</b>	10/14/2015	<b>UR Denial Date:</b>	07/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/03/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 64 year old female who sustained an industrial/work injury on 3-30-06. She reported an initial complaint of bilateral shoulder, wrist, and finger pain. The injured worker was diagnosed as having bilateral shoulder impingement, bilateral wrist sprain-strain, rule out carpal tunnel syndrome, and bilateral hands-finger pain. Treatment to date includes medication and diagnostics. Currently, the injured worker complained of bilateral shoulder pain, bilateral wrist pain with numbness, left greater than right radiating to the fingers and into the bilateral arms, and bilateral fifth digit pain. Per the primary physician's report (PR-2) on 6-22-15, exam noted tenderness of the bilateral shoulders and unspecified decreased range of motion, positive impingement testing, hypoesthesia in the C6-T1 dermatome, left greater than right, tenderness of the bilateral fifth distal phalanges, positive Phalen's test. The requested treatments include Flurbiprofen/ Capsaicin/ Camphor 10/0.025/2/1, Ketoprofen/ Cyclobenzaprine/ Lidocaine 10/3/5 #120gms, Prilosec 20mg, Norflex 100mg, Chiropractic Treatments, MRI bilateral shoulders, MRI bilateral wrist and hands, X-ray bilateral shoulder, X-ray bilateral wrists & hands, Functional Capacity Evaluation, EMG/NCV bilateral shoulders, wrists & hands, and Urinalysis for toxicology.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen/ Capsaicin/ Camphor 10/0.025/2/1 #120gms: Upheld**

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (online version).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen topical is not supported by the MTUS. Flurbiprofen/ Capsaicin/ Camphor 10/0.025/2/1 #120gms is not medically necessary.

**Ketoprofen/ Cyclobenzaprine/ Lidocaine 10/3/5 #120gms: Upheld**

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (online version).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Ketoprofen/ Cyclobenzaprine/ Lidocaine 10/3/5 #120gms is not medically necessary.

**Prilosec 20mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter (online version), Proton Pump Inhibitors (PPI's).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Prilosec 20mg #60 is not medically necessary.

**Norflex 100mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The patient has been taking the muscle relaxant for an extended period of time far longer than the short-term course recommended by the MTUS. Norflex 100mg #60 is not medically necessary.

**Chiropractic Treatments 3 x 4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The request is for 12 visits of chiropractic. The Chronic Pain Medical Treatment Guidelines allow for an initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 12 chiropractic visits is more than what is medically necessary to establish whether the treatment is effective. Chiropractic Treatments 3 x 4 is not medically necessary.

**MRI bilateral shoulders:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter (online version), Magnetic Resonance Imaging (MRI).

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

**Decision rationale:** According to the MTUS, the primary criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of the anatomy prior to an invasive procedure. The medical record is lacking documentation in any of the above criteria. MRI bilateral shoulders is not medically necessary.

**X-ray bilateral shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder Chapter (online version), Radiography.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Radiography (x-rays).

**Decision rationale:** Special studies such as an x-ray are not needed unless a red-flag condition is present. Physical exam failed to reveal any evidence of joint effusion, swelling, deformity, increased warmth, or abrasion/laceration. The findings documented on the chart note failed to meet the minimum criteria stated in the Official Disability Guidelines for x-ray imaging of the shoulder. X-ray bilateral shoulder is not medically necessary.

**EMG/NCV bilateral shoulders, wrists & hands:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, and Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Carpal Tunnel Chapter (online version).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Electromyography (EMG).

**Decision rationale:** The Official Disability Guidelines do not recommended repeat electrodiagnostic studies to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. Detailed evidence of severe and/or progressive neurological abnormalities has not been documented. EMG/NCV bilateral shoulders, wrists & hands is not medically necessary.

**Urinalysis for toxicology:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing.

**Decision rationale:** The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. There is no documentation in the medical record that a urine drug screen was to be used for any of the above indications. Urinalysis for toxicology is not medically necessary.

**Functional Capacity Evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines 2004, Independent Medical Examinations and Consultation, Chapter 7, page 137 and 138 and the Official Disability Guidelines (ODG); Fitness for Duty Chapter: Online Version, Functional Capacity Evaluation (FCE).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness For Duty, Functional capacity evaluation (FCE).

**Decision rationale:** The Official Disability Guidelines state that a functional capacity evaluation is appropriate if case management is hampered by complex issues, and the timing is appropriate; such as if the patient is close to being at maximum medical improvement or additional clarification concerning the patient's functional capacity is needed. Functional capacity evaluations are not needed if the sole purpose is to determine a worker's effort or compliance, or the worker has returned to work. There is no documentation in the medical record to support a functional capacity evaluation based on the above criteria. Functional Capacity Evaluation is not medically necessary.

**MRI bilateral wrist and hands:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Forearm, Wrists & Hand Chapter (online version), MRI's (magnetic resonance imaging).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), MRI's (magnetic resonance imaging).

**Decision rationale:** The Official Disability Guidelines recommend an MRI of the wrist or indications following trauma, suspected fracture, tumor, and suspected Kienbock's disease. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Documentation in the medical record does not support an MRI of the wrist based on the above criteria. MRI bilateral wrist and hands is not medically necessary.

**X-ray bilateral wrists & hands:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Forearm, wrist & hand chapter (online version), Radiography.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Radiography.

**Decision rationale:** The Official Disability Guidelines recommend a hand or wrist x-ray for red flags or for trauma and suspected fracture or dislocation. An x-ray may also be indicated for chronic wrist pain as the first study obtained and the patient was chronic pain with or without prior injury, or no specific area of pain specified. X-ray bilateral wrists & hands is not medically necessary.