

## Independent Medical Review Final Determination Letter

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Dated: 12/31/2013

<b>IMR Case Number:</b>	CM13-0014909	<b>Date of Injury:</b>	12/31/2002
<b>Claims Number:</b>	[REDACTED]	<b>UR Denial Date:</b>	08/13/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/22/2013
<b>Employee Name:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED] M.D		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
PLEASE REFERENCE UTILIZATION REVIEW DETERMINATION LETTER			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational 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 physician 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.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic low back, right shoulder, and elbow pain reportedly associated with an industrial injury of December 31, 2002.

Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; earlier right carpal tunnel release surgery in 1996; prior right shoulder rotator repair surgery on February 13, 2004; and extensive periods of time off of work, on total temporary disability.

The applicant has alleged pain secondary to cumulative trauma, it is noted. She has not apparently worked since 2007.

In a utilization review report of August 13, 2013, the claims administrator denied a request for topical compounded flurbiprofen cream, urine drug screen, and physical therapy. The claims administrator apparently asked the attending provider to state how much prior therapy the applicant had had in the past six months.

An earlier medical-legal report of September 27, 2010 is notable for comments that the applicant is on Social Security Disability Insurance and has failed to return to any form of work.

An earlier urine toxicology note of July 29, 2013 is noted. The claimant apparently underwent testing for numerous drugs, including six classes of barbiturates, marijuana, Soma, six different opioid metabolites, seven different antidepressant metabolites, and 12 different phenothiazine metabolites. It is stated that the results of the drug screen are consistent with the claimant's reported medication usage.

A clinical progress note of the same date, July 31, 2013, is notable for comments that the applicant is a represented former deli manager presenting with right shoulder pain. A 3/10 pain is appreciated. A positive Speed maneuver is appreciated. Limited shoulder range of motion and a negative impingement signs are appreciated. Physical therapy is endorsed. Topical compounds are also endorsed. This is described as a new patient evaluation with a new attending provider. The remainder of the file is surveyed. There is no evidence that the applicant had had prior physical therapy in 2013.

### **IMR DECISION(S) AND RATIONALE(S)**

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

**1. 1 prescription of Flurbiprofen 20% cream 30gm is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 3), Oral Pharmaceuticals, page 47, which is part of the MTUS, and the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale:

As noted in the MTUS-adopted ACOEM Guidelines in chapter 3, oral pharmaceuticals are the first-line palliative method. In this case, there is no evidence of intolerance to and/or failure of first-line oral pharmaceuticals so as to make a case for topical agents or topical compounds, which are, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines "largely experimental." It is noted that the applicant is, per recent progress reports in July 2013, using Norco (hydrocodone-acetaminophen) without any reported difficulty, impediment, and/or impairment. Usage of the topical compounded flurbiprofen containing agent is not indicated or recommended in this context. **The request for 1 prescription of Flurbiprofen 20% cream 30gm is not medically necessary and appropriate.**

**2. Six physical therapy sessions for the right shoulder is medically necessary and appropriate.**

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine Guidelines, pages 98-99, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Page 99 of the MTUS Chronic Pain Medical Treatment Guidelines endorses a general course of 9 to 10 sessions of treatment for myalgias and/or myositis of various body parts and further endorses the importance of active therapy, active modalities, and fading or tapering the frequency of physical therapy over time. In this case, it does not

appear that the applicant has had any recent therapy in 2013 or 2012, based on the documents provided for review. A six-session course of treatment is indicated, particularly given the range of motion and strength deficits appreciated on the recent office visit in July 2013. **The request for six physical therapy sessions for the right shoulder is medically necessary and appropriate.**

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### **3. 1 urine drug screen is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Drug Testing, page 43, which is part of the MTUS, and the Official Disability Guidelines (ODG), Pain Chapter, Criteria for the use of Urine Drug Testing, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

While page 43 of the MTUS Chronic Pain Medical Treatment Guidelines does endorse urine drug testing in the chronic pain population, the MTUS does not establish specific parameters for performing urine drug testing or states the frequency with which urine drug testing should be performed. As noted in the ODG Urine Drug Testing topic, criteria for pursuit of urine drug testing include categorization of an applicant into low risk, high risk, and/or moderate risk categories for which more or less frequent urine drug testing would be indicated. ODG also recommends that an attending provider provide "specific documentation with necessity of confirmatory testing of drug class panels such as antidepressants, benzodiazepines, acetaminophen, and salicylates." In this case, the attending provider tested for numerous metabolites, including several different phenothiazine metabolites, several different opioid metabolites, and several different antidepressant metabolites. It was not clearly stated why all these different drug metabolites were needed or indicated here. Therefore, the original utilization review decision is upheld. **The request for 1 urine drug screen is not medically necessary and appropriate.**

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

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