

<b>Case Number:</b>	CM13-0043821		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	08/22/2002
<b>Decision Date:</b>	03/05/2014	<b>UR Denial Date:</b>	10/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2013

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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. 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 patient is a 49-year-old female with date of injury on 08/22/2002. The progress report dated 09/24/2013 by [REDACTED] indicates the patient's diagnoses include: herniated nucleus pulposus at C5-C6; temporomandibular disorder; right shoulder impingement syndrome; right knee internal derangement; fibromyalgia; chronic fatigue syndrome; anxiety/depressive disorder secondary to industrial injury and pain; lumbar spine herniated nucleus pulposus at L4-L5. The patient continues to present with constant neck pain radiating to the bilateral upper extremities, constant right shoulder pain, constant right wrist/hand pain, low back pain with radiation to the bilateral lower extremities, knee pain on the right, and right ankle/foot pain. Her pain is rated at a 7/10. Physical exam findings include severely restricted range of motion of the cervical spine. There is positive spasms and positive compression. She has severe hyperreflexia in the upper and lower extremities. Hoffmann's test is positive on the left side. Romberg's test is positive as well. She has breakthrough weakness throughout. A request was made for the patient to continue physical therapy to the cervical spine, 2 to 3 times a week for 4 weeks. Also, requested was for the patient to continue anti-inflammatory medication including Naprosyn gel tablets #60. She was also given topical medications including ThermoCare patches #12 as well as flurbiprofen 20% gel, ketoprofen 20% 120 g/ketamine 10% gel, gabapentin 10%/cyclobenzaprine 10%, capsaicin 0.375%. The patient was also given Flexeril 10 mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy for the cervical spine (2-3 times per week for 4 weeks): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** MTUS Guidelines allows for fading of treatment frequency plus active self-directed home physical medicine. Eight to ten therapy sessions are recommended for neuralgia, neuritis, and radiculitis. The treating provider does not indicate how many sessions of physical therapy the patient has previously undergone, and when the last course of physical therapy was completed. Physical therapy reports were not available for review. The 12 sessions requested exceeds the recommended amount of sessions supported by MTUS. Therefore, recommendation is for denial.

**Naprosyn gel tablets #60: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

**Decision rationale:** MTUS states that antiinflammatories are the traditional first line of treatment to reduce pain, so activity and functional restoration can resume. This patient continues to struggle with significant pain in multiple areas. The request for continued use of antiinflammatory medication appears to be reasonable. Therefore, authorization is recommended.

**Thermacare patches: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 156-157.

**Decision rationale:** The updated ACOEM Guidelines Low Back Chapter regarding hot packs, heat wraps, and moist heat states that heat therapy including a heat wrap is recommended for treatment of acute, subacute, and chronic low back pain. This patient continues to suffer with chronic low back pain and the request for ThermoCare patches as a heat patch appears to be supported by the guidelines noted above. Therefore, authorization is recommended

**Flurbiprofen 20% gel: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** One of the areas the patient continues to complain of pain is in the right knee and right ankle. MTUS regarding topical analgesics states that nonsteroidal antiinflammatory agents may be used for osteoarthritis and tendinitis in particular that of the knee and elbow or other joints that are amenable to topical treatment. This topical gel appears to be reasonable and supported by the guidelines noted above. Therefore, authorization is recommended.

**Ketoprofen 20%/Ketamine 10% gel:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The MTUS Guidelines for topical analgesics states that any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. MTUS specifically states that the ketoprofen is not currently FDA approved for topical application due to high incidence of photocontact dermatitis. This topical cream does not appear to be supported by the guidelines noted above. Therefore, recommendation is for denial.

**Gabapentin/cyclobenzaprine/capsaicin gel:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The MTUS Guidelines regarding topical analgesic state that any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. The request for topical analgesic contains gabapentin and cyclobenzaprine, both of which are not recommended for topical use according to MTUS. Therefore, recommendation is for denial.

**Flexeril 10mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Cyclobenzaprine Page(s): 64.

**Decision rationale:** MTUS Guidelines regarding Flexeril states that it is recommended for a short course of therapy. MTUS further states that this medication is not recommended to be used for longer than 2 to 3 weeks. The records appear to indicate the patient was prescribed this medication on 07/16/2013, 09/24/2013, and 12/10/2013. As this medication is not indicated for long-term use, recommendation is for denial.