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| <b>Case Number:</b>   | CM14-0006074 |                              |            |
| <b>Date Assigned:</b> | 02/28/2014   | <b>Date of Injury:</b>       | 09/24/2012 |
| <b>Decision Date:</b> | 07/22/2014   | <b>UR Denial Date:</b>       | 01/02/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/15/2014 |

### 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 is licensed to practice in Illinois. 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 32-year-old female who reported an injury on 09/24/2012. The mechanism of injury was not specifically stated. Current diagnoses include possible lumbar discogenic pain, possible cervical discogenic pain, bilateral shoulder pain, bilateral carpal tunnel syndrome, and stress syndrome. There was no physician progress report submitted on the requesting date of 02/01/13. The latest Physician's Progress Report submitted for this review is documented on 01/27/2014. The injured worker reported persistent lower back pain with radiation into the left lower extremity, as well as neck pain with radiation into the bilateral shoulders. Previous conservative treatment includes chiropractic therapy, acupuncture, home exercises, and medication management. Physical examination on that date revealed midline tenderness in the cervical spine, cervical facet tenderness, bilateral trapezius tenderness, painful cervical range of motion, tenderness in the lumbar spine, lumbar facet tenderness, painful lumbar range of motion, positive compression testing in the bilateral wrists, positive Tinel's and Phalen's testing bilaterally, and weakness in bilateral hand grips. Treatment recommendations at that time included continuation of current medication and a followup visit in 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRILOSEC 20MG #60 (DISPENSED 2/1/2013): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. There is no evidence of cardiovascular disease or increased risk factor for gastrointestinal events. There is also no frequency listed in the current request. As such, the request is non-certified.

**FLEXERIL 7.5MG #30 (DISPENSED 2/1/2013):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute exacerbations. Flexeril should not be used for longer than 2 to 3 weeks. There was no frequency listed in the current request. Therefore, the request is not medically appropriate. As such, the request is non-certified.

**IBUPROFEN 800 MG #90 (DISPENSED 2/1/2013):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

**Decision rationale:** California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second-line option after acetaminophen. There is no documentation of osteoarthritis or an acute exacerbation of chronic pain. As guidelines do not recommend long-term use of this medication, the current request is not medically appropriate. Additionally, there is no frequency listed in the current request. Therefore, the request is non-certified.

**KETOSABI 20% MILD CREAM (DISPENSED BETWEEN 2/1/2013 AND 2/4/2013):**  
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:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is no documentation of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. The only FDA-approved topical NSAID is diclofenac. There is also no frequency listed in the current request. As such, the request is non-certified.

**GABAPENTIN 6%/KETOPROFEN 20%/LIDOCAINE HCL 6.15% ULTRACREAM, QTY: 120 GM (DISPENSED BETWEEN 2/1/2013 AND 2/4/2013):** 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:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Gabapentin is not recommended as there is no evidence for the use of an antiepilepsy drug as a topical product. The only FDA-approved topical NSAID is diclofenac. There is no evidence of a failure to respond to first-line oral medical prior to the initiation of a topical analgesic. There is also no frequency listed in the current request. As such, the request is non-certified.

**A FOLLOW UP IN 4 WEEKS (BETWEEN 2/1/2013 AND 3/1/2013):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

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

**Decision rationale:** California MTUS/ACOEM practice Guidelines state physician follow-up can occur when a release to modified, increased, or full duty is needed or after appreciable healing or recovery can be expected. There was no Physician Progress Report submitted on the requesting date of 02/01/13. Therefore, the medical necessity for a follow up visit between 2/1/2013 and 3/1/2013 cannot be determined at this time. As such, the request is noncertified.