

<b>Case Number:</b>	CM14-0100780		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	11/02/2010
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 48-year-old male was reportedly injured on 11/2/2010. The mechanism of injury was noted as a low back injury after he stood up from a sitting position. The most recent progress note, dated 4/24/2014, indicated that there were ongoing complaints of pain in the lower back, right shoulder/arm and right elbow/forearm. Physical examination demonstrated tenderness over lumbar paraspinal muscles, restricted lumbar spine range of motion, straight leg raise, heel walking and toe walking test positive in the right. Trigger points noted. Tenderness to the right shoulder, elbow and wrist with restricted range motion of the shoulder/elbow. No changes on neurocirculatory examination. EMG/NCV study, dated 4/30/2014, demonstrated right L5 and S1 radicular process superimposed on possible peripheral polyneuropathy. Results were suggested of significant lumbar paraspinal muscles spasm and/or lumbar nerve root irritation/traction injury. Previous treatment included physical therapy, chiropractic treatment and medications to include Norco 10/325 mg, Ibuprofen and Terocin. A request had been made for Physical Therapy 3 times a week for 4 weeks of the lumbar/right shoulder and elbow and wrist, Ibuprofen and Terocin, which were not certified in the utilization review on 6/3/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 3 times a week for 4 weeks, Lumbar, Right Shoulder, Elbow and Wrist:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): Chapter 9,11,12.

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

**Decision rationale:** MTUS treatment guidelines support the use of physical therapy for the management of chronic pain specifically myalgia and radiculitis and recommend a maximum of 10 visits. The claimant has multiple chronic complaints after a work-related injury in November 2010. Review, of the available medical records, fails to demonstrate an improvement in pain or function with previous physical therapy, and it is unclear how many physical therapy sessions were attended. In the absence of clinical documentation to support additional visits, this request is not considered medically necessary.

**Ibuprofen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ibuprofen Page(s): 72.

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

**Decision rationale:** Ibuprofen (Motrin) is a non-selective, non-steroidal anti-inflammatory medication which has some indication for chronic low back pain. When noting the claimant's diagnosis and clinical presentation, there is an indication for the use of Ibuprofen; however, the recommended dosage is missing from the request. Ibuprofen is available over-the-counter. Given the lack of documentation, this request is not considered medically necessary.

**Terocin:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Terocin Page(s): 112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105, 112.

**Decision rationale:** Terocin is a topical analgesic containing Lidocaine and Menthol. MTUS guidelines support topical Lidocaine as a secondary option for neuropathic pain after a trial of an antiepileptic drug or anti-depressants have failed. There is no evidence-based recommendation or support for menthol. MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class), that is not recommended, is not recommended". As such, this request is considered not medically necessary.