

<b>Case Number:</b>	CM14-0156368		
<b>Date Assigned:</b>	09/26/2014	<b>Date of Injury:</b>	07/09/2012
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2014

### 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 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 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:

This 42 year-old patient sustained an injury on 7/9/12 while employed by [REDACTED]. Request(s) under consideration include Prilosec 20mg #60 With 1 Refills, Cyclobenzaprine/ Ketoprofen/ Lido cream 240gms With 1 Refill, and IF Unit. Diagnoses include closed pelvic fracture s/p left hips reconstruction in 2012 and left arthroscopic knee repair on 1/16/14. The patient continues to treat for chronic ongoing symptoms. Report of 8/6/14 from the provider noted the patient with continued symptom complaints. Exam showed anxious mood, antalgic gait, and tenderness at thoracic, lumbar spine and at sacrum. X-rays of left knee on 8/6/14 showed post-surgical changes, tri-compartment degenerative changes and medial compartment with slight joint effusion. Conservative care has included medications, physical therapy, acupuncture, group psychotherapy, lumbar epidural steroid injection in May 2014 at left L5-S1 (no benefit). Treatment included medication refills. The request(s) for Prilosec 20mg #60 With 1 Refills was modified for #60 without refills, Cyclobenzaprine/ Ketoprofen/ Lido cream 240gms With 1 Refill and IF Unit were non-certified on 9/10/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prilosec 20mg #60 With 1 Refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular risk Page(s): 68-69.

**Decision rationale:** Prilosec (Omeprazole) medication is for treatment of the problems associated with erosive esophagitis from GERD, or in patients with hypersecretion diseases. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for Omeprazole (Prilosec) namely reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any history, symptoms, or GI diagnosis to warrant this medication. Prilosec 20mg #60 With 1 Refills is not medically necessary and appropriate.

**Cyclobenzaprine/Ketoprofen/Lido cream 240gms With 1 Refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications, Topical Cyclobenzaprine, Lidocaine Indication.

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

**Decision rationale:** Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical compound analgesic over oral NSAIDs or other pain relievers for a patient with spinal and multiple joint pain without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic for this chronic injury of 2012 without documented functional improvement from treatment already rendered. The Cyclobenzaprine/Ketoprofen/Lido cream 240gms With 1 Refill is not medically necessary and appropriate.

**IF Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 115-118.

**Decision rationale:** The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage,

increased pain relief or improved work status derived from any transcutaneous electrotherapy to warrant a purchase of an interferential unit for home use for this chronic 2012 injury.

Additionally, IF unit may be used in conjunction to a functional restoration process with return to work and exercises not demonstrated here. Submitted reports have not adequately demonstrated functional improvement derived from Transcutaneous Electrotherapy previously rendered. The IF Unit is not medically necessary and appropriate.