

<b>Case Number:</b>	CM14-0028062		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	06/28/2004
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	02/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2014

### 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 Louisiana. 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 patient is a 36 year old female who was injured on 06/28/2004 when a box fell on her head and neck. Prior treatment history has included physical therapy, chiropractic therapy, acupuncture and traction, which were beneficial but did not resolve her symptoms. The Pain Management Consultation Report dated 01/07/2014 documented the patient with complaints of headaches and neck pain. The patient rates her pain as 6/10. The patient also complains of decreased sensation in the left ulnar and medial antebrachial cutaneous nerve distributions. Objective findings on examination of the cervical spine reveal facet joint tenderness at C3 through C7. There is positive cervical compression. The patient exhibits normal cervical motion. In the upper extremities there is moderate myofascial tenderness in the left shoulder. Tinel's test is positive in the left cubital tunnel. The shoulder exhibits full range of motion. The sensory examination reveals decreased sensation in the left ulnar nerve distribution distal to the elbow. Diagnose include cervical facet arthropathy, left ulnar neuropathy at the elbow, cervical disc bulge, cervical disc disease, Left shoulder impingement, left medial epicondylitis, myofascial pain and spasm and repetitive strain/overuse syndrome of left upper extremity The plan is to continue medication, which is composed of: Norco, Neurontin, amitriptyline, Prilosec and topical pain compound formulation. The patient is recommended to undergo surgical evaluation of the ulnar nerve entrapment by a neurosurgeon. Physical therapy is recommended two times per week for four weeks. The utilization report dated denied the request for physical therapy 8 sessions as the objective outcome of prior physical therapeutic intervention for this chronic injury is not specified. Current request for additional physical therapy at this time is not substantiated and consideration of transition to home exercise program should be undertaken. The request for tramadol 20% cream was not certified as the need for this compound transdermal medication is not clearly established. The request for Prilosec 20 mg #60 was non-certified as

there is no evidence that the claimant presents with diagnosis of gastritis or that the claimant is maintained on nonsteroidal anti-inflammatory medications to substantiate the need of this proton pump inhibitor which is generally indicated to address the increased risk of gastric irritation when the claimant is maintained on non-steroid medications. Regarding the request for Ketoprofen 20% cream 30 grams, the claimant has widely spread pain complaints not specific to one locality. In this case presentation the use of transdermal anti-inflammatory medication is not clearly substantiated.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **TRAMADOL 20 PERCENT CREAM 30 GRAMS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The need for this compound medication is not clearly established. As per guidelines the use of topical compounded medications are considered experimental and there is no proven efficacy for this delivery format in most pain-related situations. The patient has widespread pain complaints not specific to one locality. This request is not medically necessary.

#### **KETOPROFEN 20 PERCENT CREAM 30 GRAMS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Topical NSAIDs are generally recommended for short-term use for acute sprain/strains and not indicated for chronic conditions. The patient has widespread pain complaints not specific to one locality. In the case presentation the use of this medication is not clearly substantiated and as such is not medically necessary.

#### **CYCLOBENZAPRINE 10 PERCENT WITH GABAPENTIN 10 PERCENT 30 GRAMS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicates there is no evidence or peer-review literature to support this medication. Therefore it is not medically necessary.

**PHYSICAL THERAPY X8-HEAD POSTURE, SHOULDERS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** As per CA MTUS guidelines, physical medicine is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The most recent update did not reveal any significant change in clinical presentation with no specific ADL/work-related deficits or goals. As the objective findings of prior physical therapeutic intervention for this injury is not specified current request for additional therapy is non-certified.

**PRILOSEC 20 MG QTY 60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request for Prilosec 20 mg #60 was non-certified as there is no evidence that the claimant presents with diagnosis of gastritis or that the claimant is maintained on nonsteroidal anti-inflammatory medications to substantiate the need of this proton pump inhibitor which is generally indicated to address the increased risk of gastric irritation when the claimant is maintained on non-steroid medications.