

<b>Case Number:</b>	CM14-0029716		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	08/28/1998
<b>Decision Date:</b>	08/11/2014	<b>UR Denial Date:</b>	02/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/07/2014

### 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 Pain Management, 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 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 63-year-old female with an injury date of August 28, 1998. Based on the December 13, 2013 progress report provided by [REDACTED] the patient complains of neck pain, bilateral upper shoulder pain, and low back pain/stiffness. She is unable to function and has decreased range of motion for both her cervical and lumbar spine. The patient has positive impingement for her right shoulder and decreased grip strength in both hands. She also has tender cervical paraspinal C1 to C7 and L1 to L5 muscles with triggering. Her diagnoses include neck and bilateral shoulder pain; low back pain, polyarthralgia, hip and ankle pain; depression, dyspepsia, fibromyalgia, and hypertension.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril (10mg - 1 at bedtime, #30): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain). Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain), Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available) Page(s): 64.

**Decision rationale:** The request for Flexeril is not medically necessary. According to the Chronic Pain Medical Treatment Guidelines, cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. Based on review of the reports, the prescribed 30 tablets of Flexeril exceeds the 3 weeks, which is what guidelines recommend. The patient appears to be prescribed this medication on a long-term basis. Therefore, the request is not medically necessary.

**A Lumbar Stabilizing Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online, Low Back Chapter, Lumbar Supports.

**Decision rationale:** The request for a lumbar stabilizing brace is not medically necessary. The ACOEM Practice Guidelines state that lumbar support has not been shown to have any lasting benefit beyond the acute phase of symptom relief. ACOEM Practice Guidelines also states the use of a back belts as a lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security. The Official Disability Guidelines (ODG) also states that it is not recommended for prevention and for treatment. It is an option for fracture, spondylolisthesis, documented instability, and for nonspecific low back pain (very low quality evidence.) Given the lack of guidelines support for use of lumbar bracing, the request is not medically necessary.

**Celebrex (200mg - 1 every day, #30):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory Medications, Medications for Chronic Pain Page(s): 60,61, 22.

**Decision rationale:** The request is for Celebrex is not medically necessary. The patient began taking Celebrex on December 13, 2013. Review of the reports does not provide any discussion regarding the efficacy of Celebrex. The Chronic Pain Medical Treatment Guidelines support use of NSAIDs for chronic pain. However, guidelines require documentation of pain assessment and function as related to the medication used. In this case, there is lack of any documentation regarding what Celebrex has done for this patient's pain and function. Therefore, the request is not medically necessary.

**Protonix (40mg - 1 every morning, #30):** 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 & cardiovascular risk Page(s): 69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** The request for Protonix is not medically necessary. The Chronic Pain Medical Treatment Guidelines support the usage of Proton Pump Inhibitors (PPIs) for gastric side effects due to NSAID use. The Official Disability Guidelines also state that PPIs are recommended for patients at risk for gastrointestinal events. The treating physician has not documented any gastrointestinal symptoms. Guidelines do not allow prophylactic use of PPI's without documentation of GI risk factors. Given the lack of any discussion regarding GI risk factors or GI symptoms, the request is not medically necessary.

**Terocin Cream (two bottles):** Upheld

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

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

**Decision rationale:** The request for Terocin Cream is not medically necessary. Terocin cream contains salicylate, capsaicin and lidocaine. The Chronic Pain Medical Treatment Guidelines provide clear discussion regarding compounded topical products for use in chronic pain. It states that if one of the components is not recommended, then the entire component is not recommended. In this case, Terocin cream contains salicylate, which is a topical NSAID. Topical NSAID is indicated for peripheral arthritic and tendinitis pain. This patient does not present with peripheral joint arthritis or tendinitis but struggles with neck pain and bilateral upper shoulder pain. Furthermore, topical lidocaine is recommended for neuropathic pain only and this patient does not present with neuropathic pain. Therefore, the request is not medically necessary.

**Medrox Patches (six boxes):** Upheld

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

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

**Decision rationale:** The request for Medrox patches is not medically necessary. Medrox patch contains salicylate, capsaicin, and lidocaine. Chronic Pain Medical Treatment Guidelines provide clear discussion regarding compounded topical products for use in chronic pain. It states that if one of the components is not recommended, then the entire component is not recommended. In this case, Medrox patch contains salicylate, which is a topical NSAID. Topical NSAID is indicated for peripheral arthritic and tendinitis pain. This patient does not present with peripheral joint arthritis or tendinitis but struggles with left shoulder pain which radiates to his neck and

arms. Furthermore, topical lidocaine is recommended for neuropathic pain only and this patient does not present with neuropathic pain. Therefore, the request is not medically necessary.

**Aquatic Therapy (12 sessions - 2 times per week for 6 weeks): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy, Physical Medicine Page(s): 22, 98-99.

**Decision rationale:** The request for aquatic therapy is not medically necessary. The Chronic Pain Medical Treatment Guidelines state that aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. In this case, there is no documentation of extreme obesity or a need for reduced weight bearing. There is no indication of why the patient is unable to tolerate land-based therapy. Furthermore, the requested 12 sessions exceeds what is recommended by guidelines for myalgia/myositis, neuralgia/neuritis. Therefore, the request is not medically necessary.