

<b>Case Number:</b>	CM14-0092582		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	08/12/2012
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	05/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2014

### 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 Internal Medicine 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 injured worker is a 39 year old female who had a work related injury on 08/12/12. Mechanism of injury was not described. Most recent clinical documentation submitted for review was dated 04/25/14, the injured worker was in for followed up, pain in the cervical spine 8/10, frequent and radiating to bilateral hands with numbness, lumbar spine 8/10 frequent and radiating to left leg, and left shoulder 8/10 and frequent. She took anexsia three times and reported improvement in her pain from 9 to 6/10 after taking the medication. Physical examination injured worker was 5'1" tall and weighed 150 pounds. Physical examination of the cervical spine revealed limited range of motion. Shoulder depression test was positive on the right. Physical examination of the lumbar spine revealed limited range of motion. Kemp test was positive on the right. Physical examination of the left shoulder revealed limited range of motion with flexion and abduction at 160 degrees, extension and adduction at 40 degrees, and internal and external rotation at 70 degrees there was a negative arm drop test. Supraspinatus test was positive on the left shoulder. Diagnoses status post left shoulder subacromial decompression and debridement. Cervical spine sprain/strain rule out disc herniation. Rotator cuff tendinitis of the left shoulder. Lumbar spine sprain/strain. She had urine drug screen on 04/21/10 which was consistent with prescribed treatment. There was no clinical documentation submitted on functional benefit on the medication or VAS scores with and without medication. Prior utilization review on 05/14/14 was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen/Cyclobenzaprine/Menthol cream (20% 10% 14%) 180gm:** 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:** California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: flurbiprofen and cyclobenzaprine which have not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended, and therefore not medically necessary.

**Anexsia 7.5/325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines opioids Page(s): 74-80.

**Decision rationale:** Current evidenced-based guidelines indicate patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is insufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic medications. Documentation does not indicate a significant decrease in pain scores with the use of medications. Therefore medical necessity has not been established. However, these medications cannot be abruptly discontinued due to withdrawal symptoms, and medications should only be changed by the prescribing physician. The request is not medically necessary.

**MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck chapter, Magnetic resonance imaging (MRI)

**Decision rationale:** The request for MRI of cervical spine is not medically necessary. The clinical documentation submitted for review does not support the request. The physical

examination does not reveal any neurological abnormalities. As such, medical necessity has not been established.

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, Magnetic resonance imaging (MRI)

**Decision rationale:** The request for MRI of lumbar spine is not medically necessary. The clinical documentation submitted for review does not support the request. The physical examination does not reveal any neurological abnormalities. As such, medical necessity has not been established.