

<b>Case Number:</b>	CM15-0183979		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	10/23/2013
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Tennessee, Florida, Ohio  
 Certification(s)/Specialty: Surgery, Surgical Critical Care

### 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 44 year old male injured worker suffered an industrial injury on 10-23-2013. The diagnoses included cervical disc protrusion, radiculopathy, sprain and cervicgia, lumbar sprain, disc disease, left shoulder rotator cuff tear and impingement, left knee chondromalacia and internal derangement, left ankle sprain and tenosynovitis. On 8-27-2015, the treating provider reported constant moderate neck, low back, left knee pain. There was constant mild pain of the left shoulder and left ankle. On exam the cervical spine, lumbar spine, left shoulder and left knee had reduced range of motion. There was tenderness to the cervical spine, lumbar spine, left shoulder, left ankle and left knee. Prior treatment included physical therapy at least 3 sessions and chiropractic therapy at least 4 sessions without further recommendation or goals documented. The Utilization Review on 9-3-2015 determined non-certification for Flurbiprofen 20%/Baclofen 5%/Camphor 2%/Menthol 2%/Dexamethasone 0.2%/Hyaluronic Acid 0.2% cream 240 gm, Amitriptyline HCL 10%/Gabapentin 10%/Bupivacaine 5%/Hyaluronic acid 0.2% cream 240 gm, Physical therapy 2 times 3 (Left shoulder, cervical and lumbar spine), Chiro 2 times 3 (Low back) and MRI (Left Knee).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 20%/Baclofen 5%/Camphor 2%/Menthol 2%/Dexamethasone 0.2%/Hyaluronic Acid 0.2% cream 240 gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The California MTUS guidelines address the topic of compound medication prescriptions. In accordance with California MTUS guidelines, topical analgesics are considered "Largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines go on to state that, "There is little to no research to support the use of many of these agents." The guideline specifically says, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Compounded medications are not subject to FDA oversight for purity or efficacy. Therefore, based on the submitted medical documentation, the request for Flurbiprofen 20%/Baclofen 5%/Camphor 2%/Menthol 2%/Dexamethasone 0.2%/Hyaluronic Acid 0.2% cream is not medically necessary.

**Amitriptyline HCL 10%/Gabapentin 10%/Bupivacaine 5%/Hyaluronic acid 0.2% cream 240 gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The California MTUS guidelines address the topic of compound medication prescriptions. In accordance with California MTUS guidelines, topical analgesics are considered "Largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines go on to state that, "There is little to no research to support the use of many of these agents." The guideline specifically says, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Compounded medications are not subject to FDA oversight for purity or efficacy. Therefore, based on the submitted medical documentation, the request for Amitriptyline HCL 10%/Gabapentin 10%/Bupivacaine 5%/Hyaluronic acid 0.2% cream is not medically necessary.

**Physical therapy 2 times 3 (Left shoulder, cervical and lumbar spine):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): General Approach, Diagnostic Criteria, Initial Care.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of physical therapy for this patient. The California MTUS Guidelines for physical medicine state that: "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Guidelines also state that practitioners should, "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." This patient has previously had physical therapy, but now his physician is requesting additional sessions. The guidelines recommend fading of treatment frequency with transition to a home exercise program, which this request for a new physical therapy plan does not demonstrate. The results of the patient's prior PT sessions and recommendations are not documented. Therefore, based on the submitted medical documentation, the request for additional physical therapy is not medically necessary.

**Chiro 2 times 3 (Low back): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this intervention for this patient. The California MTUS Guidelines state that Chiropractic manipulation is recommended for the treatment of chronic pain that has acute flares or "requires therapeutic care." However, it is "not recommended for elective for maintenance therapy." The medical records support that this patient has chronic pain, which has been stable with no recent flare-ups or acute interventions. The patient's pain appears to be at a steady state for which he has been receiving chiropractic manipulation in the past two years. The results of the patient's prior treatments, goals of treatment and results of former therapy are not documented in the medical literature. MTUS does not support the need for manipulation as maintenance therapy. There are no goals listed in the charting provided. Therefore, based on the submitted medical documentation, medical necessity for chiropractic therapy has not been established; the request is not medically necessary.

**MRI (Left Knee): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee chapter.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Diagnostic Criteria, Special Studies.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of an MRI for this patient. The MTUS guidelines recommend that an MRI is indicated

when objective findings are unclear or there is a need for imaging to proceed with surgical planning. Indiscriminant imaging will result in false-positive findings, such as bone spurs and normal degenerative disease, which may not be the source of painful symptoms and do not warrant surgery. In this patient's case, the patient's physical exam does not document any red flag symptoms or new neurologic deficits to warrant a knee MRI study. The patient's complaints of pain are subjective. Therefore, based on the submitted medical documentation, the request for a MRI of the knee is not medically necessary.