

<b>Case Number:</b>	CM14-0131319		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	05/17/2011
<b>Decision Date:</b>	10/17/2014	<b>UR Denial Date:</b>	07/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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 Occupational 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 patient is a 59-year-old female who has submitted a claim for carpal tunnel syndrome associated with an industrial injury date of May 17, 2011. Medical records from 2013 to 2014 were reviewed. The patient complained of neck pain, low back pain and numbness radiating to the bilateral legs, and right wrist pain. Physical examination findings include limitation of motion of the cervical spine due to pain; +3 tenderness over the cervical paravertebral muscles, bilateral trapezii; positive cervical compression test; limitation of motion of the lumbar spine; +3 tenderness of lumbar paravertebral muscles and bilateral SI joints; positive Kemp's and straight leg raise; and limitation of motion of the right wrist. The diagnoses were status post right carpal tunnel release, right shoulder pain and dysfunction, residuals after prior arthroscopic surgery, rule out rotator cuff pathology, cervical spine strain, lumbar spine strain, and status post right shoulder A/S SAD, debridement and biceps tenotomy. Treatment to date has included tramadol, Naprosyn, Flexeril, Prilosec, Methoderm, cervical steroid injection, chiropractic therapy, physical therapy, right carpal tunnel release, and home exercises. Utilization review from July 25, 2014 denied the requests for Acupuncture because guideline recommends a 4 session trial prior to additional treatment; Ibuprofen 800 milligrams due to lack of functional benefit and lack of support for long-term use; Flexeril 7.5mg because this not supported for long-term use either and other medications in this class have a greater safety profile; Prilosec 20mg milligrams because there was no history of GERD, risk factors for GERD, or GERD complaints; and Methoderm cream because salicylate compounded with other ingredients confer no proven added benefit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** CA MTUS Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. In this case, there was no documentation that medications were reduced, not tolerated, or has failed to relieve pain. There was also no evidence of failure of other ongoing conservative treatments such as physical therapy. The medical necessity has not been established because there was no clear indication for the request. In addition, the request did not specify number of treatment sessions and which body part treatment was directed to. Therefore, the request for Acupuncture is not medically necessary.

**Ibuprofen 800milligrams:** 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 2009, NSAIDS Page(s): 67-72.

**Decision rationale:** As stated on page 72 of CA MTUS Chronic Pain Medical Treatment Guidelines, ibuprofen can be taken for mild to moderate pain as 400 mg PO every 4-6 hours as needed. Doses greater than 400 mg have not provided greater relief of pain. NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. In this case, Ibuprofen 800mg was taken as far back as March 2014. However, overall pain relief and functional outcome from Ibuprofen use was not documented. Furthermore, the guidelines do not recommend Ibuprofen dose of greater than 400mg. The long-term use of Ibuprofen is not in conjunction with guideline recommendation as well. The medical necessity has not been established. There was no compelling rationale concerning the need for variance from the guideline. In addition, the request did not specify number of medication to dispense. Therefore, the request for Ibuprofen 800 milligrams is not medically necessary.

**Flexeril 7.5mg:** 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 2009: CYCLOBENZAPRINE Page(s): 41-42.

**Decision rationale:** According to page 41- 42 of the CA MTUS Chronic Pain Medical Treatment Guidelines, sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, Flexeril intake was noted as far back as February 2014. However, there was no objective evidence of continued analgesia and functional improvement derived from its use. The guideline does not recommend long-term use of this medication. Furthermore, muscle spasm and acute exacerbation of pain were not evident in the records submitted. The medical necessity has not been established. There was no clear indication for the request. In addition, the request failed to specify quantity of medication to dispense. Therefore, the request for Flexeril 7.5 mg is not medically necessary.

**Prilosec 20mg milligrams:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 2009: NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

**Decision rationale:** According to page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors should be prescribed in patients on NSAID therapy who are at risk for GI events. Risk factors includes age > 65; history of peptic ulcer, GI bleed, or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; and high dose or multiple NSAID use. Use of PPI > 1 year has been shown to increase the risk of hip fracture. Patients with intermediate or high risk factors should be prescribed proton pump inhibitor. In this case, the patient has been on chronic high dose ibuprofen. However, continued use of this NSAID has been deemed medically unnecessary. There are no other noted risk factors for developing gastrointestinal events. There was also no evidence of gastrointestinal issues based on the most recent progress reports. The medical necessity has not been established. There was no compelling rationale concerning the need for variance from the guideline. In addition, the request failed to specify quantity of medication to dispense. Therefore, the request for Prilosec 20mg milligrams is not medically necessary.

**Menthoderm cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals Page(s): 105.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 2009, Salicylate topicals page 105; Topical Analgesics, page 111 Page(s): 105; 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Capsaicin, topical

**Decision rationale:** Page 111 of CA MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Methoderm gel contains methyl salicylate and menthol. Page 105 states that while the guidelines referenced support the topical use of methyl salicylates, the requested Methoderm has the same formulation of over-the-counter products such as BenGay. It has not been established that there is any necessity for this specific brand name. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, or methyl salicylate, may in rare instances cause serious burns. In this case, Methoderm cream was used as far back as March 2014. However, there was no objective evidence of continued analgesia and functional benefit from its use. Moreover, there were no documented failed trials with first-line antidepressants or anticonvulsants. Likewise, it has not been established that there is any necessity for a specific brand name topical salicylate compared to an over the counter formulation. The medical necessity has not been established. There was no compelling rationale concerning the need for variance from the guideline. In addition, the request did not specify number of medication to dispense. Therefore, the request for Methoderm cream is not medically necessary.