

<b>Case Number:</b>	CM15-0115806		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	02/06/2014
<b>Decision Date:</b>	09/24/2015	<b>UR Denial Date:</b>	05/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/15/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 (IW) is a 54-year-old male who sustained an industrial injury on 02/06/2014. Diagnoses include chronic myofascial pain syndrome, chronic cervical spine strain and chronic right rotator cuff syndrome. Treatment to date has included medications, splinting and activity modifications. According to the progress notes dated 4/21/15, the IW reported right shoulder and cervical spine pain and numbness of the right hand. On examination, range of motion was decreased by 10% in all planes, sensation was decreased in the right hand, strength was decreased in the right shoulder and the cervical spine, spasms were present in the right trapezius muscle and Spurling's test was positive on the right. Bilateral upper extremity reflexes were normal. A request was made for ergonomic modifications including computer screen; physical therapy twice a week for four weeks; Omeprazole 20mg once daily; Neurontin 600mg, three times daily; Voltaren ER 100mg, once daily and Lidopro x two; the IW wished to avoid surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ergonomic modifications including computer screen: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 264, 166. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 6-11.

**Decision rationale:** The current request is for Ergonomic modifications including computer screen. The RFA is dated 04/21/15. Treatment to date has included medications, splinting and activity modifications. The patient has returned to work full-time with some modifications. The ACOEM Practice Guidelines, 2nd edition (2004), chapter 1, pages 6-11 states, "The clinician may recommend work and activity modification or ergonomic redesign of the workplace to facilitate recovery and prevent recurrence." According to the progress note dated 4/21/15, the patient reported right shoulder and cervical spine pain and numbness of the right hand. On examination, range of motion was decreased by 10% in all planes, sensation was decreased in the right hand, strength was decreased in the right shoulder and the cervical spine, spasms were present in the right trapezius muscle and Spurling's test was positive on the right. The patient has returned to work full-time and the treater is requesting Ergonomic modifications including computer screen. ACOEM Guidelines support ergonomic evaluations for the workplace to accommodate ergonomic changes to hasten the employee's return to full activity. Evaluation for needed changes appears reasonable; however, the current request is for modifications without specifying exactly what changes are required and for what reason. Given the lack of any specific discussion regarding the request, it IS NOT medically necessary.

**Physical therapy 2 times a week for 4 weeks:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

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

**Decision rationale:** The current request is for Physical therapy 2 times a week for 4 weeks. The RFA is dated 04/21/15. Treatment to date has included medications, splinting and activity modifications. The patient has returned to work full-time with some modifications. The MTUS Chronic Pain Management Guidelines, PHYSICAL MEDICINE, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." According to the progress notes dated 4/21/15, the patient reported right shoulder and cervical spine pain and numbness of the right hand. There are no physical therapy reports provided for review. The exact number of completed physical therapy visits to date and the objective response to therapy were not documented in the medical reports. QME report from 11/20/14 indicates that the patient has had PT in the past and recommended additional 8 sessions per year as needed for flare-ups. The treater states that the patient has completely forgotten the previously learned home exercises and is requesting a course of 8 sessions for reinforcing a HEP. There is no indication of any recent PT sessions and a course of 8 sessions to re-learn the necessary home exercises is reasonable. This request IS medically necessary.

**Omeprazole 20 mg 1 tab daily:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, cardiovascular risks.

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

**Decision rationale:** The current request is for Omeprazole 20 mg 1 tab daily. The RFA is dated 04/21/15. Treatment to date has included medications, splinting and activity modifications. The patient has returned to work full-time with some modifications. MTUS pg. 69, NSAIDs, GI symptoms & cardiovascular risk Section states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e. g. , NSAID + low-dose ASA)." "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." According to the progress notes dated 4/21/15, the patient reported right shoulder and cervical spine pain and numbness of the right hand. The treater has requested a refill of Omeprazole, which the patient has been using since 12/26/14. The medical records indicate that the patient has a history of GERD with taking NSAIDs. The treater has noted GERD in the review of systems. The patient has been utilizing Voltaren on a long-term basis, and is currently managing her GI symptoms with the use of Omeprazole. Given the patient's history of GERD, the use of Omeprazole is indicated. This request IS medically necessary.

**Neurontin 600 mg 1 tab thrice daily:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18-19.

**Decision rationale:** The current request is for Neurontin 600 mg 1 tab thrice daily. The RFA is dated 04/21/15. Treatment to date has included medications, splinting and activity modifications. The patient has returned to work full-time with some modifications. MTUS Guidelines, Gabapentin section pages 18, 19 has the following: Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. According to the progress notes dated 4/21/15, the patient reported right shoulder and cervical spine pain and numbness of the right hand. The treater has requested a refill of Neurontin, which the patient has been using since 12/26/14. The patient presents with neuropathic pain and meets the indication for using this medication; but recommendation for further use cannot be supported, as this medication has been non-efficacious for this patient. The treater states in the 05/20/15 report "the patient was given Neurontin for arm paresthesia secondary to her myofascial pain syndrome and radiculopathy, but since this medicine was not sufficient in controlling her numbness, she was prescribed LidoPro." Given this patient has been using this medication chronically, with no documentation of specific efficacy and functional benefit, the request IS NOT medically necessary.

**Voltaren extended release 100 mg 1 tablet daily:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory Medications Page(s): 22.

**Decision rationale:** The current request is for Voltaren extended release 100 mg 1 tablet daily. The RFA is dated 04/21/15. Treatment to date has included medications, splinting and activity modifications. The patient has returned to work full-time with some modifications. MTUS Guidelines, Anti-Inflammatory Medications, page 22 states that anti-inflammatory are the traditional first-line treatment to reduce pain, so activity and functional restoration can resume, but long-term use may not be warranted. For medication use in chronic pain, MTUS page 60 also requires documentation of the pain assessment and function as related to the medication use. Specific to Voltaren, ODG Guidelines, and Pain Chapter under Diclofenac Sodium states, not recommended as first line due to increased risk profile. A large systematic review of available evidence on NSAIDs confirms that diclofenac, a widely used NSAID, poses an equivalent risk of cardiovascular events to patients, as did rofecoxib (Vioxx), which was taken off the market. According to the progress notes dated 4/21/15, the patient reported right shoulder and cervical spine pain and numbness of the right hand. The treater has requested a refill of Voltaren extended release, which the patient has been using since 12/26/14. The treater states that Voltaren is to help the patient's inflammation. ODG supports Voltaren when other NSAIDs have failed and the patient is at a very low risk profile. There is no evidence in provided medical records that other NSAIDs have been trialed and failed, nor has treater addressed patient's risk profile. The request does not meet guidelines indication. Therefore, the request IS NOT medically necessary.

**Lidopro x 2:** Upheld

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

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

**Decision rationale:** The current request is for Lidopro x 2. The RFA is dated 04/21/15. Treatment to date has included medications, splinting and activity modifications. The patient has returned to work full-time with some modifications. LidoPro lotion contains Capsaicin, Lidocaine, Menthol, and methyl salicylate. The MTUS Topical Analgesics section, page 111 has the following: the FDA for neuropathic pain has designated Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) for orphan status. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of Lidocaine whether creams, lotions or gels- are indicated for neuropathic pain. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. According to the progress notes dated 4/21/15, the patient reported right shoulder and cervical spine pain and numbness of the right hand. The treater has requested a refill of LidoPro. About Lidopro for this patient's chronic pain, this medication is not indicated for this patient's chief complaint. In addition, MTUS guidelines do not support topical Lidocaine in formulations other than patches. Therefore, the entire compound cream is rendered invalid and the request IS NOT medically necessary.