

<b>Case Number:</b>	CM15-0063144		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	08/29/2012
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	03/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 42-year-old female who sustained an industrial injury on 08/23/2012. Current diagnoses include cervicalgia, myofascial pain, facet-mediated pain, and occipital neuralgia. Treatments to date include medications and an epidural steroid injection. Diagnostic studies include a MRI of the cervical spine. Current complaints include neck and shoulder pain. The injured worker presented on 02/19/2015 for a follow-up evaluation. The injured worker reported an improvement in symptoms with the use of ibuprofen. Upon examination, there was paraspinal muscle tenderness to palpation, painful extension and rotation of the cervical spine, 2+ deep tendon reflexes, 5/5 motor strength, and negative Spurling's maneuver. Recommendations included additional physical therapy, an interlaminar epidural injection, compounded cream, a prescription for meloxicam 15 mg, a Toradol 60 mg injection, and continuation of modified work restrictions. A Request for Authorization form was submitted on 02/19/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy evaluation, QTY: 1: Upheld**

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

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

**Decision rationale:** The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The injured worker has been previously treated with a course of physical therapy. There was no documentation of objective functional improvement following the initial course of treatment. Additional sessions would not be supported in this case. As such, the request is not medically necessary.

**Physical therapy, 2 times weekly for the cervical spine, QTY: 12:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The injured worker has been previously treated with a course of physical therapy. There was no documentation of objective functional improvement following the initial course of treatment. Additional sessions would not be supported in this case. As such, the request is not medically necessary.

**Chiropractic evaluation, QTY: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58 - 59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

**Decision rationale:** The California MTUS Guidelines recommend manual therapy and manipulation for chronic pain if caused by a musculoskeletal condition. Treatment is recommended as a therapeutic trial of 6 visits over 2 weeks. The injured worker has been previously treated with chiropractic therapy. There was no documentation of objective functional improvement following the initial course of treatment. Additional sessions would not be supported in this case. As such, the request is not medically necessary.

**Chiropractic treatment, cervical spine, QTY: 6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

**Decision rationale:** The California MTUS Guidelines recommend manual therapy and manipulation for chronic pain if caused by a musculoskeletal condition. Treatment is recommended as a therapeutic trial of 6 visits over 2 weeks. The injured worker has been previously treated with chiropractic therapy. There was no documentation of objective functional improvement following the initial course of treatment. Additional sessions would not be supported in this case. As such, the request is not medically necessary.

**Pain cream: Baclofen 2%, Cyclobenzaprine 2%, Diclofenac 3%, Gabapentin 6%, Lidocaine 2%, QTY: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Muscle relaxants are not recommended for topical use. The only FDA approved topical NSAID is Diclofenac 1% gel. Lidocaine is not recommended in the form of a cream, lotion, or a gel. Gabapentin is not recommended for topical use. There is also no frequency listed in the request. As such, the request is not medically necessary.