

<b>Case Number:</b>	CM13-0013705		
<b>Date Assigned:</b>	03/10/2014	<b>Date of Injury:</b>	04/09/2003
<b>Decision Date:</b>	05/14/2014	<b>UR Denial Date:</b>	08/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2013

### 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 Emergency 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:

Patient with date of injury on April 9, 2003. Injury due to repetitive work. Diagnosis of cervical spine pain with radiculopathy, L upper extremity complex regional pain syndrome, post L shoulder rotator cuff repair with closed subacromial decompression and L carpal tunnel release. Patient has a history of carpal tunnel of L wrist and underwent surgery in May of 1990. Patient also developed bilateral shoulder pains requiring surgery on 9/05 and 7/07. Pain to L (left) shoulder, L forearm and wrist and neck worsened since 2011. Medical records reviewed from primary treating physician and consultants. Last report available until 9/6/13. Patient complains of L shoulder pain radiating to L neck, L back and L chest. L arm is weak and drops things. Worsens with movement or activity. Pain is 7-9/10. L wrist has dull pain radiating to L forearm and fingers. Numbness reported. Complains of swelling and numbness. Pain is 7-8/10. Objective exam reveals L shoulder is higher than R. Head and neck are tilted to R. Tenderness to upper trapezius, paravertebral muscles and upper thorax on L side. Negative cervical compression and Spurling test. Limited range of motion(ROM) of neck. Diffuse decreased sensation to left upper extremity. Mild decrease motor strength in L arm. L shoulder has tenderness along acromioclavicular joint, bicep tendon groove and rotator cuff with limited exam due to limited ROM (range of motion). Pain noted to L wrist along dorsoradial aspect with negative tests for carpal tunnel. X-rays of cervical spine(3/13) reveals osteophytosis and disc space narrowing at C2-3 with hypertrophy of apophyseal joints at C4-5, C5-6 and C6-7. Xray of L shoulder was negative except for post surgical changes. Xray of L wrist was benign except for lunotriquetral joint narrowing with erosions. Current medications include naproxen, topical creams. Was preciously on norco but notes mention that patient had poor control and poor tolerance and so was switched to Ultram which has helped with the pain. Utilization review is for prescription for Ultram 50mg #60 with 1 refill and ketoprofen 20%/cyclobenzaprine 3%/lidocaine 3.15%

transdermal 120ml with 1 refill. Last utilization review on August 6, 2013 which modified the prescription of ultram with no refills and certified prescription for naproxen and physical therapy. It recommended non-certification for the transdermal cream.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **PRESCRIPTION OF ULTRAM 50MG, #60 WITH ONE REFILL: 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 Page(s): 76 - 79.

**Decision rationale:** Ultram/Tramadol is a synthetic opioid. According to the Chronic Pain Medical Treatment Guidelines, there are specific guidelines concerning management of chronic pain with opioids that should be followed while patient is on opioid therapy. Patient meets criteria for initiation of opioids for pain control. However, guidelines recommend visits to treating physician every two weeks during the initial trial phase and then every 1-2months and lengthened out as therapy is stabilized. The patient has only begun use of tramadol and should be more closely monitored. While the use of tramadol is medically appropriate, the additional refill of the prescription does not meet the Chronic Pain Medical Treatment Guidelines criteria for monitoring for treatment. The request for tramadol, sixty count with one refill, is not medically necessary or appropriate.

#### **PRESCRIPTION OF KETOPROFEN 20%/ CYCLOBENZAPRINE 3% / LIDOCAINE 6.15% TRANSDERMAL CREAM 120ML WITH ONE REFILL: 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 Page(s): 111-113.

**Decision rationale:** The requested product is a compounded cream composed of multiple medications. According to the Chronic Pain Medical Treatment Guidelines, "Any compounded product that contain one drug or drug class that is not recommended is not recommended." Ketoprofen: ketoprofen is an NSAID (non-steroidal anti-inflammatory drug). it is not FDA approved for use as a topical compound. According to the Chronic Pain Medical Treatment Guidelines, topical NSAIDs have inconsistent results but is better than placebo for pain during initial 2weeks of pain with diminishing results over time. It is currently only recommended for short term use and for osteoarthritis of joints that are amenable for topical treatment(such as elbow or knees). There is no evidence to support its use for spine, hip or shoulder pains. In conclusion, NSAID topical are not recommended for long term use and there is no evidence to support its use for shoulder related pain. A non-FDA approved use of Ketoprofen is not

recommended. Cyclobenzaprine: Topical muscle relaxants like cyclobenzaprine are not recommended according to the Chronic Pain Medical Treatment Guidelines due to lack of evidence of efficacy. Lidocaine: Topical lidocaine is recommended for post-herpetic neuralgia only although it may be considered as off-label use as a second line agent for peripheral neuropathic pain. It may be considered for peripheral neuropathic pain only after a trial of 1st line agent. There is no documentation of an attempt of trial with a 1st line agent and is therefore not recommended. Since all components of this compounded product is not recommended, the entire compound is not recommended. The request for compound medication ketoprofen 20%/ cyclobenzaprine 3%/lidocaine 6.15% transdermal cream 120 ml, with one refill, is not medically necessary or appropriate.