

Case Number:	CM13-0056169		
Date Assigned:	12/30/2013	Date of Injury:	01/30/2009
Decision Date:	05/06/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	11/21/2013

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 43 YO female with date of injury of 01/30/2009. The listed diagnoses per [REDACTED] dated 10/14/2013 are: 1. Right shoulder impingement with rotator cuff tendinitis/tendinopathy 2. Status post right shoulder arthroscopy 3. Cervical sprain/strain with myofascitis with associated 3mm disc protrusion at C5-6 4. Thoracolumbar sprain/strain with myofascitis Final Determination Letter for IMR Case Number CM13-0056169 3 5. Intervertebral disc syndrome, lumbar spine 6. Lumbar radiculitis/sciatica According to the progress report the patient complains of moderate to severe neck/upper back, middle back, and low back pain with associated muscle spasms. The patient also reports intermittent episodes of moderate right arm/shoulder pain with associated stiffness and residual weakness. She also reports continuing pain radiating distally into her right arm. The physical examination shows significantly decreased range of motion on flexion, extension, lateral bending bilaterally in the neck and back regions secondary to pain. Straight leg raise is positive and Lasegue's test elicits sciatica extending into her right leg. There is a 1+ tenderness noted about the right trapezius and right rhomboid muscle groups. The patient also has a significantly decreased range of motion on the extremes of flexion, abduction and internal/external rotation of the right shoulder secondary to pain. The treater is requesting compounded cream cyclobenzaprine/ketoprofen and flurbiprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Cyclobenzaprine/Ketoprofen (DOS 10/14/13) and prospective usage, two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

Decision rationale: This patient presents with chronic neck, upper back, mid back, low back and right shoulder pain. The treater is requesting a retrospective decision for the compound cream cyclobenzaprine/ketoprofen. The MTUS guidelines p111 states for Topical Analgesics, "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." MTUS further states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, cyclobenzaprine a muscle relaxant is not recommended as a topical product. Therefore, recommendation is for denial.

Retrospective request for Flurbiprofen (DOS 10/14/13) and prospective usage, 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL CREAMS Page(s): 111.

Decision rationale: This patient presents with chronic neck, upper back, mid back, low back and right shoulder pain. The treater is requesting a retrospective decision for flurbiprofen. The MTUS guidelines p111 states for Topical Analgesics, "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." For Flurbiprofen, a topical NSAID, MTUS states that these have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment of osteoarthritis. Topical NSAIDs are indicated for peripheral joint arthritis/tendinitis type of problems. It is also indicated for short term use, between 4-12 weeks. In this case, the patient does not present with osteoarthritis that would warrant the use of a topical NSAID. Therefore, recommendation is for denial.