

<b>Case Number:</b>	CM13-0065528		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	06/11/2002
<b>Decision Date:</b>	04/21/2014	<b>UR Denial Date:</b>	12/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/13/2013

### 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 and Rehabilitation and is licensed to practice in Illinois. 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 70-year-old male who reported an injury on 06/11/2002. The mechanism of injury was not provided in the medical records. The patient is diagnosed with cervical spine sprain and thoracic spine sprain. His symptoms are noted to include pain in the neck and left shoulder with radiation to the bilateral upper extremities and numbness and tingling in his left hand. His physical examination findings included tenderness and spasm to palpation over the trapezius muscles and over the left shoulder, and decreased sensation in the left thumb. His treatment plan was noted to include discontinuation of Ambien, and prescriptions for Doral and Anaprox. He was also given topical compounded creams to reduce impact on his gastrointestinal system.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DORAL 15 MG #:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Insomnia Treatment Section

**Decision rationale:** According to the Official Disability Guidelines (ODG), Doral is FDA approved for sleep maintenance insomnia. However, the guidelines further indicate that these medications are recommended only for short term use due to the significant risk of tolerance, dependence, and adverse effects. The clinical information submitted for review failed to provide details regarding the patient's insomnia, including whether the patient has complaints of sleep onset, sleep maintenance, sleep quality, or next day functioning insomnia. Further, the documentation does not indicate whether the request for Doral is intended to be used for short term only. In the absence of further details regarding the patient's complaint of insomnia and intended use of Doral, the request is not supported. As such, the request is non-certified.

**ANAPROX 550 MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 70-73.

**Decision rationale:** According to the California MTUS Guidelines, it is generally recommended that the lowest effective dose be used for all NSAID medications for the shortest duration of time, consistent with the individual patient treatment goals. The clinical information submitted for review failed to provide a detailed medication history with documentation regarding the patient's need for NSAID medications, reported side effects from use of NSAIDs medications, and lower dosing attempted prior to the current dose. As the patient has been shown to be taking Anaprox for an extended period of time, further details are needed regarding the patient's outcome with use of this medication, reported side effects, and specific treatment goals with use. In the absence of these details, the request for continued use is not supported.

**FLURBIPROFEN 25%, 30 GM:** 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): 111-113.

**Decision rationale:** According to the California MTUS Guidelines, topical analgesics are largely experimental in use with limited evidence demonstrating efficacy and safety. It further states that topical analgesics are primarily used in the treatment of neuropathic pain when trials of anticonvulsants and antidepressants have failed. In addition, the guidelines specify that any compounded product that contains at least 1 drug that is not recommended is not recommended. In regard to topical NSAIDs, the guidelines indicate that studies have shown them to be more superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with diminishing effects over another 2 week period. The guidelines also state that there is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder, and the only currently FDA approved topical formulation of an NSAID is

topical Voltaren gel 1%. The clinical information submitted for review failed to show evidence that the patient has been diagnosed with osteoarthritis to warrant use of topical NSAIDs. Additionally, as her symptoms are noted to be in the spine and shoulder, topical NSAIDs are not supported as there is little evidence regarding the use of topical NSAIDs for the treatment of the spine, hip, or shoulder. Additionally, as Voltaren 1% gel is the only currently FDA approved topical NSAID; the request for topical Flurbiprofen is not supported. Further, as the patient is noted to be already taking an oral NSAID medication, it is unclear why she requires a topical formulation as well. For the reasons noted above, the request is non-

**CYCLOBENZAPRINE 10 % TRAMADOL COMPOUND CREAM 120 GM:** Upheld

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

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

**Decision rationale:** According to the California MTUS Guidelines, topical analgesics are largely experimental in use with limited evidence demonstrating efficacy and safety. It further states that topical analgesics are primarily used in the treatment of neuropathic pain when trials of anticonvulsants and antidepressants have failed. In addition, the guidelines specify that any compounded product that contains at least 1 drug that is not recommended is not recommended. According to the California MTUS Guidelines, there is no evidence for use of muscle relaxants as topical products. As the requested topical compound is noted to include Cyclobenzaprine and the guidelines do not support topical muscle relaxants, the requested product is not supported. As such, the request is non-certified.