

<b>Case Number:</b>	CM14-0022053		
<b>Date Assigned:</b>	05/09/2014	<b>Date of Injury:</b>	07/03/2013
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	02/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/21/2014

### 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 Texas. 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 injured worker is a 39-year-old who reported an injury on July 3, 2013 secondary to an unknown mechanism of injury. The injured worker was evaluated on February 3, 2014 for reports of right elbow pain with muscle spasms rated at 7/10, radicular low back pain with muscle spasms rated at 7/10, and right leg pain rated at 5/10. The exam noted the injured worker indicated the medications do offer him temporary relief of pain and improve his ability to have a restful sleep. The exam noted tenderness to palpation to the right elbow, lumbar spine, and right leg. The exam also noted decreased sensation and motor strength to the right lower extremity. The diagnoses included unspecified sprain of the elbow, intervertebral disc displacement, and status post lower joint release. The treatment plan included physical therapy, chiropractic treatment, and medication therapy. The request for authorization was not found in the documentation provided. The rationale for the medications was found in the office notes.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 BOTTLE OF SYNAPRYN 10MG/ML ORAL SUSPENSION 500ML:** 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 Opioids Page(s): 74-95.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There was an evaluation of the injured worker's pain level and function; however, there is a lack of significant evidence of an evaluation of risk for aberrant drug use behavior and side effects. The request for one bottle of synapryn 10mg/ml oral suspension 500ml is not medically necessary or appropriate.

**1 BOTTLE OF TABRADOL 1MG/ML ORAL SUSPENSION 250ML:** 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 Muscle Relaxants Page(s): 63-66.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommend the use of muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The documentation provided indicates the injured worker has been prescribed muscle relaxants since at least October 3, 2013. This time frame exceeds the time frame to be considered short-term. The request for one bottle of tabradol 1mg/ml oral suspension 250ml is not medically necessary or appropriate.

**1 CONTAINER OF COMPOUNDED KETOPROFEN 20% IN PLO GEL 120 GRAMS:**  
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:** The Chronic Pain Medical Treatment Guidelines state topical NSAIDs (non-steroidal anti-inflammatory drugs) have been shown in meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another two-week period. The guidelines further state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is a lack of clinical evidence of efficacy of other treatments in the documentation provided. The request for one container of compound ketoprofen 20% in PLO gel, 120 grams, is not medically necessary or appropriate.

**1 CONTAINER OF COMPOUNDED CYCLOPHENE 5% IN PLO GEL 120 GRAMS:**  
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:** There is no evidence for use of any other muscle relaxant besides baclofen a topical product. The guidelines further state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is also a lack of clinical evidence of efficacy of other treatments in the documentation provided. The request for one container of compound cyclophene 5% in PLO gel, 120 grams, is not medically necessary or appropriate.