

Case Number:	CM15-0018775		
Date Assigned:	02/06/2015	Date of Injury:	02/20/2002
Decision Date:	04/08/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/02/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 59 year old female who sustained an industrial injury on 1/26/15 in a slip and fall involving the left side of her body. She is currently experiencing moderate neck, left wrist; mid and low back pain and severe left hip and knee pain. She has severe left shoulder pain at extremes of motion. She is 6 months post-operative left shoulder arthroscopic decompression and rotator cuff repair. Medications are Norco, Prilosec, Xanax and topical creams Ketoprofen, Gabapentin and Tramadol. Diagnoses include status post left shoulder arthroscopic decompression and rotator cuff repair; cervical sprain/ strain; right shoulder impingement with posttraumatic arthrosis of the acromioclavicular joint; left wrist sprain/ strain; left knee internal derangement, status post prior arthroscopy (4/5/13); left leg thrombophlebitis, chronic; status vena cava umbrella cage placement; obesity; diabetes; lumbar sprain/ strain, chronic; depression; insomnia. Treatments to date include physical therapy medications, steroid injection into left hip (12/15/14) with good relief of pain. The rationale for the retrospective request for Cyclobenzaprine 10% 120 GM Cream, Date of Service 12/18/14 was not documented. On 1/26/15 Utilization Review non-certified the retrospective request for Cyclobenzaprine 10% 120 GM Cream, Date of Service 12/18/14 citing MTUS: Chronic Pain Medical Treatment Guidelines: Topical Analgesics.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Cyclobenzaprine 10% 120 gram Cream DOS: 12/18/2014: 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 topical analgesics Page(s): 111-113 of 127.

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines the only topical analgesic medications indicated for usage include anti-inflammatories, lidocaine, and capsaicin. There is no known efficacy of any other topical agents to include cyclobenzaprine. Per the MTUS, when one component of a product is not necessary the entire product is not medically necessary. Considering this, the request for topical cyclobenzaprine is not medically necessary.