

Case Number:	CM15-0139471		
Date Assigned:	07/29/2015	Date of Injury:	12/30/2010
Decision Date:	09/24/2015	UR Denial Date:	07/15/2015
Priority:	Standard	Application Received:	07/17/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 68-year-old female injured worker suffered an industrial injury on 12-30-2015. The diagnoses included left total knee replacement 2-27-2015, lumbar herniated disc, spondylosis and radiculopathy, cervical spine herniated disc with radiculopathy, thoracic herniated disc, bilateral knee chondromalacia, and right shoulder impingement. The diagnostics included computerized tomography lumbar discogram, computerized tomography cervical and lumbar magnetic resonance imaging. The treatment included acupuncture, chiropractic therapy, epidural steroid injections, orthopedic surgery, physical therapy and medication. On 7-2-2015, the treating provider reported neck and low back pain. She reported 80% increase in the low back pain. The provider noted the Omeprazole was prescribed for gastritis. The neck pain was rated 8 out of 10 that radiated to the shoulders and arms with numbness and weakness in the hands to the point where she dropped things. The low back was rated 9 out of 10 that extended to the buttocks that had become worse along with numbness to the feet. On exam, there was a slow gait with use of a cane along with tenderness of the cervical and lumbar muscles. The injured worker had not returned to work. The requested treatments included Cyclobenzaprine, Omeprazole and Capsaicin 0.05% & Cyclobenzaprine 4% cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg Qty: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: The 68-year-old patient complains of neck pain, rated at 8/10, radiating to bilateral shoulders and arms, and lower back pain, rated at 9/10, radiating to the buttocks, as per progress report dated 07/02/15. The request is for CYCLOBENZAPRINE 7.5mg QTY: 30.00. The RFA for the case is dated 06/30/15, and the patient's date of injury is 12/30/10. The patient is status post left total knee replacement on 02/27/15, as per the operative report. Diagnoses, as per progress report dated 07/02/15, included lumbar HNP with stenosis, lumbar instability with spondylolisthesis, lumbar radiculopathy, cervical HNP with stenosis, cervical radiculopathy, thoracic HNP with stenosis, bilateral knee chondromalacia patellae, right shoulder impingement and bursitis, and left shoulder SLAP lesion. Medications included Norco, Flexeril, Prilosec, Gabapentin and Ketoprofen cream. The patient is also status post right shoulder arthroscopy in 2014, status post bilateral CTS release in 2013, and status post arthroscopic medial meniscectomy in 2013, as per progress report dated 06/09/15. The patient is temporarily totally disabled, as per progress report dated 06/19/15. MTUS pg 63-66 states and Muscle relaxants section: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, Cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and relaxant effects. In this case, a prescription for Cyclobenzaprine / Flexeril is first noted in QME report dated 04/10/12. It is not clear when the medication was prescribed for the first time and if the patient has taken the muscle relaxant consistently since then or not. Nonetheless, all progress reports since 01/09/15 document its use. As per progress report dated 06/30/15, medications reduce the pain by 60% and allow her to sleep better. However, this is not specific to Cyclobenzaprine. Additionally, MTUS recommends it only for a short period (no more than 2-3 weeks). Therefore, the request IS NOT medically necessary.

Omeprazole 20mg Qty: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: The 68-year-old patient complains of neck pain, rated at 8/10, radiating to bilateral shoulders and arms, and lower back pain, rated at 9/10, radiating to the buttocks, as per progress report dated 07/02/15. The request is for OMEPRAZOLE 20mg QTY: 60.00. The RFA for the case is dated 06/30/15, and the patient's date of injury is 12/30/10. The patient is status post left total knee replacement on 02/27/15, as per the operative report. Diagnoses, as per progress report dated 07/02/15, included lumbar HNP with stenosis, lumbar instability with spondylolisthesis, lumbar radiculopathy, cervical HNP with stenosis, cervical radiculopathy, thoracic HNP with stenosis, bilateral knee chondromalacia patellae, right shoulder impingement and bursitis, and left shoulder SLAP lesion. Medications included Norco, Flexeril, Prilosec, Gabapentin and Ketoprofen cream. The patient is also status post right shoulder arthroscopy in 2014, status post bilateral CTS release in 2013, and status post arthroscopic medial meniscectomy in 2013, as per progress report dated 06/09/15. The patient is temporarily totally disabled, as per progress report dated 06/19/15. MTUS pg 69, NSAIDs, GI symptoms & cardiovascular risk Section states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." In this case, a prescription for Omeprazole "for gastric upset" is first noted in progress report dated 01/09/15, and the patient has been taking the medication consistently since then. While recent orthopedic progress report dated 07/02/15 does not document the use of NSAIDs, progress report from the primary care physician, dated 07/14/15, documents the use of Naproxen. Prophylactic use of PPI is indicated by MTUS. However, the treater has not provided GI risk assessment for prophylactic use of PPI, as required by MTUS. Provided progress reports do not show evidence of gastric problems, and there is no mention of GI issues except constipation. This request does not meet the criteria enlisted by the guideline. Therefore, the request IS NOT medically necessary.

1 oz of CM4 cream- Capsaicin 0.05% & Cyclobenzaprine 4%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: The 68-year-old patient complains of neck pain, rated at 8/10, radiating to bilateral shoulders and arms, and lower back pain, rated at 9/10, radiating to the buttocks, as per progress report dated 07/02/15. The request is for CM4 CREAM- CAPSAICIN 0.05% & CYCLOBENZAPRINE 4%. The RFA for the case is dated 06/30/15, and the patient's date of injury is 12/30/10. The patient is status post left total knee replacement on 02/27/15, as per the operative report. Diagnoses, as per progress report dated 07/02/15, included lumbar HNP with stenosis, lumbar instability with spondylolisthesis, lumbar radiculopathy, cervical HNP with stenosis, cervical radiculopathy, thoracic HNP with stenosis, bilateral knee chondromalacia patellae, right shoulder impingement and bursitis, and left shoulder SLAP lesion. Medications included Norco, Flexeril, Prilosec, Gabapentin and Ketoprofen cream. The patient is also status

post right shoulder arthroscopy in 2014, status post bilateral CTS release in 2013, and status post arthroscopic medial meniscectomy in 2013, as per progress report dated 06/09/15. The patient is temporarily totally disabled, as per progress report dated 06/19/15. Regarding topical analgesics, MTUS guidelines on page 111 and Topical Analgesics section, state that there is no evidence for use of any muscle relaxants such as Cyclobenzaprine as a topical product. The MTUS guidelines p111 and Topical Analgesics section on topical lidocaine states, "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." 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, a prescription for CM4 cream is first noted in progress report dated 06/02/15. Prior progress reports document the use of other topical formulations such as Capsaicin cream, Lidopro lotion and Ketoprofen cream. The treater does not explain the reason for the switch. As per progress report dated 06/30/15, medications reduce the pain by 60% and allow her to sleep better. Nonetheless, MTUS does not support the use of Cyclobenzaprine in topical form. While the guidelines support the use of Lidocaine in form of a patch; creams, lotions and gels are not supported. The Guidelines also provide clear discussion regarding topical compounded creams on pg 111. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Additionally, the treater does not indicate where and how the cream will be used. Hence, the request IS NOT medically necessary.