

<b>Case Number:</b>	CM15-0139603		
<b>Date Assigned:</b>	07/30/2015	<b>Date of Injury:</b>	12/20/2013
<b>Decision Date:</b>	09/18/2015	<b>UR Denial Date:</b>	07/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### 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, 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 36 year old female, who sustained an industrial injury on December 20, 2013. She reported a right shoulder injury. The injured worker was diagnosed as having right shoulder internal derangement. Diagnostic studies were not included in the provided medical records. Treatment to date has included chiropractic care. There were no noted previous injuries or dates of injury, and no noted comorbidities. The most recent physician report is dated April 7, 2014. The injured worker reported intermittent to frequent, mild to moderate burning pain of the right shoulder. Her pain was relieved by medications, rest, and activity restrictions. The physical exam revealed tenderness at the delto-pectoral groove and on the supraspinatus insertion, and decreased shoulder range of motion. There was normal sensation, mild decreased muscles strength, and normal deep tendon reflexes of the right upper extremity. Her work status was deferred to the primary care physician. Requested treatments include: Ketoprofen 20% cream, Cyclobenzaprine 5% cream, and Synapryn 10mg/1mL oral suspension.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketoprofen 20% cream 167 grams:** 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 Page(s): 111-112 of 127.

**Decision rationale:** Regarding the request for topical ketoprofen, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Ketoprofen is not FDA approved for a topical application. Within the documentation available for review, there's no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of topical ketoprofen. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the topical ketoprofen is for short term use, as recommended by guidelines. Additionally, Ketoprofen is not FDA approved for a topical application. In the absence of clarity regarding those issues, the currently requested topical ketoprofen is not medically necessary.

**Cyclobenzaprine 5% cream 110 grams:** 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 Page(s): 113 of 127.

**Decision rationale:** Regarding the request for topical cyclobenzaprine, Chronic Pain Medical Treatment Guidelines state that topical muscle relaxants are not recommended. They go on to state that there is no evidence for the use of any muscle relaxants as a topical product. Therefore, in the absence of guideline support for topical muscle relaxants, the currently requested topical cyclobenzaprine is not medically necessary.

**Synapryn 10mg/1mL 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 Page(s): 50 and 75-79 of 127. Decision based on Non-MTUS Citation X Other Medical Treatment Guideline or Medical Evidence:<http://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=22416>.

**Decision rationale:** Regarding the request for Synapryn, this compound is noted to contain tramadol and glucosamine. With regard to opioids such as tramadol, California MTUS Chronic Pain Medical Treatment Guidelines state that, due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side

effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. With regard to glucosamine, it is recommended as an option in patients with moderate arthritis pain, especially for knee osteoarthritis. Within the documentation available for review, there is no indication that the medication is improving the patient's pain (in terms of percent reduction in pain or reduced NRS), no discussion regarding aberrant use, no documentation of knee osteoarthritis, and no clear rationale for the use of this oral suspension compounded kit rather than the FDA-approved oral tablet forms. In the absence of such documentation, the currently requested Synapryn is not medically necessary.