

Case Number:	CM15-0148968		
Date Assigned:	08/12/2015	Date of Injury:	08/16/2014
Decision Date:	09/29/2015	UR Denial Date:	07/16/2015
Priority:	Standard	Application Received:	07/31/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 20-year-old female, who sustained an industrial injury on August 16, 2014. The injured worker was diagnosed as having right shoulder, hip and wrist strain-sprain rule out derangement, low back pain, lumbar strain-sprain rule out herniated nucleus pulposus (HNP) and rule out radiculitis lower extremity. Treatment to date has included electromyogram, nerve conduction study, pain management, physical therapy, shockwave therapy and neurostimulation therapy. A progress note dated May 21, 2015 provides the injured worker complains of right shoulder right wrist, low back and hip pain. The shoulder pain radiates down the arm with spasm and rated 6 out of 10. Her wrist is rated 3-4 out of 10 with spasm and weakness with numbness and tingling in the hand and fingers. There is lumbar area spasm with radiating numbness and tingling in the legs rated 7-8 out of 10. The right hip is rated 6-7 out of 10 with spasm. She reports medication provides relief. Physical exam notes tenderness to palpation of the affected areas with decreased range of motion (ROM). There is a retrospective request for Ketoprofen cream, Cyclobenzaprine cream and Synapryn suspension.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Ketoprofen 20% cream 167gm (DOS 05/21/2015): 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: MTUS and ODG recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Per ODG and MTUS, Ketoprofen is "not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis and photosensitization reactions." As such the request for Retrospective Ketoprofen 20% cream 167gm (DOS 05/21/2015) is not medically necessary.

Retrospective Cyclobenzaprine 5% cream 110gm (DOS 05/21/2015): 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: MTUS and ODG recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS states regarding topical muscle relaxants, "Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." Topical Cyclobenzaprine is not indicated for this usage, per MTUS. As such, the request for Retrospective Cyclobenzaprine 5% cream 110gm (DOS 05/21/2015) is not medically necessary.

Retrospective Synapryn 10mg/1ml oral suspension 500ml (DOS 05/21/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-94.

Decision rationale: Synapryn is the liquid version of Tramadol that also contains glucosamine and Tramadol. MTUS states regarding tramadol "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." The treating physician did not provide sufficient documentation that the patient has failed her trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, no documentation was provided which discussed the setting of goals for the use of Synapryn prior to the initiation of this medication. While MTUS does state that Synapryn (Tramadol) may be used for neuropathic pain, it is "not recommended as a first-line therapy". The treating physician has not provided documentation of a trial and failure of first line therapy. As such, the request for Retrospective Synapryn 10mg/1ml oral suspension 500ml (DOS 05/21/2015) is not medically necessary.