

Case Number:	CM15-0056214		
Date Assigned:	04/01/2015	Date of Injury:	02/05/2013
Decision Date:	05/06/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	03/24/2015

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:

This 59 year old male sustained an industrial injury to the low back on 2/5/13. Previous treatment included magnetic resonance imaging, lumbar fusion, physical therapy, cortisone injections and medications. In an initial comprehensive primary treating report dated 12/31/14, the injured worker complained of low back pain, rated 7/10 on the visual analog scale, with spasms and radiation to bilateral lower extremities, numbness and tingling. Physical exam was remarkable for lumbar spine with tenderness to palpation to the paraspinal musculature and spasms and restricted range of motion. Current diagnoses included lumbago, status post lumbar spine surgery and rule out lumbar spine radiculopathy. The treatment plan included medications (Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine, Terocine patches and Ketoprofen cream), lumbar spine x-rays, a transcutaneous electrical nerve stimulator unit for home use, a hot/cold unit, acupuncture three times a week for six weeks, chiropractic therapy three times a week for six weeks, lumbar spine computed tomography scan, bilateral lower extremity electromyography/nerve conduction velocity test and a pain management specialist referral for epidural steroid injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% cream #167gm: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: Regarding the request for ketoprofen cream, CA MTUS states that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested ketoprofen cream is not medically necessary.

Cyclobenzaprine 5% cream #110gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: Regarding the request for cyclobenzaprine, CA MTUS states that muscle relaxants are not supported for topical use. As such, there is no clear indication for this topical medication and no clear rationale for its use in spite of the CA MTUS recommendations has been provided. Given the above, the requested cyclobenzaprine cream is not medically necessary.

Synapryn 10mg/1 ml #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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 50 and 75-79 of 127.

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 and function (in terms of percent reduction in pain or reduced NRS and specific examples of functional improvement), 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.