

<b>Case Number:</b>	CM14-0097004		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	08/22/2002
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	05/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2014

### 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. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 50-year-old woman sustained a work related injury on August 22, 2002. Subsequently, she developed a chronic neck and back pain. According to a progress note dated on April 29 2014, the patient reported chronic neck pain, headaches and chronic back pain. The patient numbness and tingling in both upper extremities associated to a right knee pain. Her physical examination demonstrated cervical tenderness with limited range of motion, positive Spurling's test in both upper extremities, limited range of motion of the lumbar spine and positive straight leg raise bilaterally. The provider requested authorization to use the medications mentioned below.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Naprosyn Gel Tab BID #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI, Cardiovascular or Renovascular.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-Selective NSAIDS Page(s): 72.

**Decision rationale:** Naproxen (Naprosyn): delayed release (EC-Naprosyn), as Sodium salt (Anaprox, Anaprox DS, Aleve [otc]) Generic available; extended-release (Naprelan): 375 mg.

Different dose strengths and formulations of the drug are not necessarily bioequivalent. Dosing Information: Osteoarthritis or ankylosing spondylitis: Dividing the daily dose into 3 doses versus 2 doses for immediate-release and delayed-release formulations generally does not affect response. Morning and evening doses do not have to be equal in size. The dose may be increased to 1500 mg/day of naproxen for limited periods when a higher level of analgesic/anti-inflammatory activity is required (for up to 6 months). Naprosyn or naproxen: 250-500 mg PO twice daily. Anaprox: 275-550 mg PO twice daily. (total dose may be increased to 1650 mg a day for limited periods). EC-Naprosyn: 375 mg or 500 mg twice daily. The tablet should not be broken, crushed or chewed to maintain integrity of the enteric coating. Naprelan: Two 375 mg tablets (750 mg) PO once daily or two 500 mg tablets (1000 mg) once daily. If required (and a lower dose was tolerated) Naprelan can be increased to 1500 mg once daily for limited periods (when higher analgesia is required). Pain: Naprosyn or naproxen: 250-500 mg PO twice daily. The maximum dose on day one should not exceed 1250 mg and 1000 mg on subsequent days. NSAID should be used for the shortest duration and the lowest dose. There is no documentation from the patient file that the provider titrated Naprosyn to the lowest effective dose and used it for the shortest period possible. Furthermore, there is no documentation that the provider followed the patient for NSAID adverse reactions that are not limited to GI side effect, but also may affect the renal function. There is also concern about the limited effectiveness of previous use of Naprosyn. Therefore, the request for Naprosyn Gel Tab BID #60 is not medically necessary.

**Heat Wraps 1 QD PRN #12 Boxes: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 12, page 299

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), [http://www.worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#SPECT](http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT)

**Decision rationale:** According to ODG guidelines, cold therapy is recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel. There is no evidence to support the efficacy of hot and cold therapy in this patient who was suffering from a chronic back and neck pain and who was injured on 2002. Hot and Cold therapy is usually approved during the acute post op setting to treat post op inflammatory swelling. There are no controlled studies supporting the use of hot/cold therapy in chronic back and neck pain.

Therefore, the request for [REDACTED] Heat Wraps 1 QD PRN #12 Boxes are not medically necessary.

**Flexeril 10mg TID PRN #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (flexeril), muscle relaxants for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** According to MTUS guidelines, Flexeril, a non-sedating muscle relaxants, is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. In this case, Flexeril has been used since at least April 2014. This time frame of treatment exceeds the guideline recommendation without clear efficacy: the patient continued to have pain despite Flexeril use, which indicates a lack of treatment efficacy. Therefore the request for authorization of Flexeril 10mg TID PRN #90 is not medically necessary.

**Ketoprofen 20% Ketamine 10% 120gm apply 2 - 3x daily:** 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.

**Decision rationale:** According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111); topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no evidence that Ketoprofen gel is recommended as topical analgesics for chronic pain. Ketoprofen gel, a topical analgesic is not recommended by MTUS guidelines. Furthermore, Ketoprofen was reported to have frequent photo contact dermatitis. Based on the above Ketoprofen 20% Ketamine 10% 120gm apply 2 - 3x daily is not medically necessary.