

<b>Case Number:</b>	CM14-0215501		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	08/29/2011
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/22/2014

### 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. 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, Arizona  
 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 injured worker is 57 year old male who sustained an industrial injury on 8/29/11. The mechanism of injury was not provided. He currently is complaining of post-operative spinal pain and pain may be due to hardware movement. Diagnoses include status post spinal fusion L4-5, L5-S1 (3/24/14); lumbar disc disease; lumbar radiculopathy. Treatments to date include post-operative physical therapy and random urine drug screens. In the progress note dated 10/9/14 the treating provider has requested hydrocodone/APAP 2.5/ 325 mg #30, 30 day supply; Fenoprofen Calcium 400 mg #30, 30 day supply; Omeprazole 20 mg #30, 30 day supply; cyclobenzaprine 7.5 mg #60; docuprene 100 mg #60; Lenza Patch #30; Ketoprofen Cream 20% #2; Sprix Nasal Spray (Toradol) #5 for pain and inflammation control. He notes that the urine toxicology screen is consistent with the medications prescribed. He further notes the medications will hopefully improve lumbar and cervical functionality, decrease pain, improve quality of life and perform activities of daily living with minimal assistance. On 11/19/14 Utilization Review non-certified the requests for hydrocodone/APAP 2.5/ 325 mg #30, 30 day supply; Fenoprofen Calcium 400 mg #30, 30 day supply; Omeprazole 20 mg #30, 30 day supply;; cyclobenzaprine 7.5 mg #60; docuprene 100 mg #60; Lenza Patch #30; Ketoprofen Cream 20% #2; Sprix Nasal Spray (Toradol) #5 citing MTUS: Chronic Pain Medical Treatment Guidelines: Opioids, MTUS: Non-steroidal Anti-inflammatory Drugs, Pain Medical Treatment Guidelines, MTUS: Cyclobenzaprine, www.nlm.nih.gov, MTUS Chronic Pain Medical treatment Guidelines: Topical Analgesics, MTUS: Toradol respectively.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/APAP 5/325mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management of Opioid use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California MTUS Guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The injured worker was noted to undergo urine drug screens. The clinical documentation submitted for review indicated the injured worker had pain of 6/10 with medications. However, the level without medications was not provided. There was documentation the injured worker was being monitored for side effects. The objective functional benefit was not provided. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for hydrocodone/APAP 5/325 mg #60 is not medically necessary.

**Feniprofen 400mg, #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** The California MTUS Guidelines indicate that NSAIDS are recommended for short term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had pain of 6/10 with medications. However, the level without medications was not provided. There was documentation the injured worker was being monitored for side effects. The objective functional benefit was not provided. Additionally, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for fenoprofen 400 mg #30 is not medically necessary.

**Cyclobenzaprine 7.5mg, #60:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. There was a lack of documentation indicating efficacy for the requested medication. Additionally, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for cyclobenzaprine 7.5 mg #60 is not medically necessary.

**Omeprazole 20mg, #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

**Decision rationale:** The California MTUS Guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and/or injured workers at high risk of gastrointestinal events with cardiovascular disease and are also for the treatment of dyspepsia secondary to NSAID therapy. The documentation indicated the injured worker had cardiac disease and that the medication was being utilized to treat gastritis from Nsaids. However, the efficacy for the requested medication was not provided. Additionally, there was a lack of documentation to support the need for the NSAID and as such, the proton pump inhibitor would not be supported. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for omeprazole 20 mg #30 is not medically necessary.

**Docuprene 100mg, #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.nlm.nih.gov](http://www.nlm.nih.gov).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Initiation of Opioid Therapy Page(s): 77.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend that when initiating opioid therapy, prophylactic treatment of constipation should be initiated. The clinical documentation submitted for review failed to provide the efficacy for the requested medication. There was a lack of documentation indicating the injured worker had a side effect of constipation. Additionally, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for docuprene 100 mg #60 is not medically necessary.

**Lenza Patch #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, Topical Analgesic, Lidocaine Page(s): 105, 111, 112.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended...The guidelines indicate that topical lidocaine (Lidoderm) may be 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). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. The clinical documentation submitted for review failed to provide the injured worker had a trial of antidepressants and anticonvulsants. The rationale was for the use for neuropathic pain. There was a lack of documentation of exceptional factors, as this medication, which is a combination medication of lidocaine and topical salicylate, is not recommended. Lidoderm is the only recommended topical patch with lidocaine. The request as submitted failed to indicate the frequency and the body part to be treated for the requested medication. Given the above, the request for Lenza patch #30 is not medically necessary.

**Ketprofen Cream 20% #2: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicates that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Ketoprofen is not currently FDA approved for a topical application. The clinical documentation submitted for review failed to indicate the injured worker had a trial and failure of antidepressants and anticonvulsants. The documentation indicated the rationale for the use of the medication was that the injured worker could not take excessive oral NSAIDs due to a cardiac condition. However, as ketoprofen is not FDA approved for topical application, this request would not be supported. The request as submitted failed to indicate the frequency and the body part to be treated. There was a lack of documentation indicating the body part and frequency for the requested medication. There was a lack of documented rationale indicating a necessity for 2 tubes of the medication. Given the above, the request for Ketoprofen cream 20% #2 is not medically necessary.

**Sprix Nasal Spray (Toradol) #5: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Sprix.

**Decision rationale:** The Official Disability Guidelines indicate that Sprix nasal spray is recommended for the short-term treatment of moderate to moderately severe pain requiring analgesia at the opioid level. The total duration of use is not to exceed 5 days. It is not recommended as a first line medication for chronic pain. The clinical documentation submitted for review failed to provide a rationale for the requested medication. Additionally, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Sprix nasal spray (Toradol) #5 is not medically necessary. Additionally, there was a lack of documented rationale for the quantity of 5.