

Case Number:	CM14-0216164		
Date Assigned:	01/06/2015	Date of Injury:	05/22/2014
Decision Date:	02/28/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/24/2014

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

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 patient is a 43 year old male with an injury date of 05/22/14. The 10/27/14 progress report states that the patient presents with lower back pain radiating into the lower extremities with numbness and tingling sensation greater on the right side. Pain is constant and is rated 6/10. Examination reveals tenderness to palpation of the lumbar paraspinal muscles with slight decreased sensation to pin-prick and light touch at the L4-5 and S1 dermatomes bilaterally. The patient's diagnoses include: 1. Lumbar spine sprain/strain rule out HNP. 2. Lumbar radiculopathy. The patient is undergoing physical therapy and acupuncture treatment for the lumbar spine along with shockwave therapy. An EMG study is requested. Continuing medications are listed as Synapryn, Deprizine, Dicopanol, Fanatrex, Tabradol, Cyclobenzaprine, and Ketoprofen Cream. Terocin patches are requested. The utilization review is dated 12/02/14. One treatment report was provided for review dated 10/27/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen cream 20%, 165 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The patient presents with lower back pain radiating into the lower extremities rated 6/10. The current request is for Ketoprofen 20% Cream #165 gm. The RFA is not included. The 12/02/14 utilization review states the RFA is dated 10/27/14. MTUS Topical Analgesics guidelines pages 111 and 112 has the following regarding topical creams, 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 further states, Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. The sole treatment report provided does not discuss this medication. It is unknown how long it has been prescribed for the patient. In this case, the medication contains Ketoprofen which is not approved by the FDA for topical formulation. Lacking recommendation by MTUS, the request is not medically necessary.

Cyclobenzaprine 5% cream, 100 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 78, 93 - 94, and 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The patient presents with lower back pain radiating into the lower extremities rated 6/10. The current request is for Cyclobenzaprine 5% Cream #100 gm. The RFA is not included. The 12/02/14 utilization review states the RFA is dated 10/27/14. MTUS Topical Analgesics guidelines pages 111 and 112 has the following regarding topical creams, 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. The sole treatment report provided does not discuss this medication. It is unknown how long it has been prescribed for the patient. In this case, the medication contains Cyclobenzaprine which is not approved for topical formulation. Therefore, the requested topical cream is not recommended by MTUS, and the request is not medically necessary.

Synapryn 10 mg/ml, 500 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 78, 93 - 94, and 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opioids Page(s): 76-78, 88-89.

Decision rationale: The patient presents with lower back pain radiating into the lower extremities rated 6/10. The current request is for Synapryn (10 gm/1 ml) #500 ml (Tramadol

Hydrochloride-an opioid analgesic). The RFA is not included. The 12/02/14 utilization review states the RFA is dated 10/27/14. MTUS Criteria for Use of Opioids, pages 76 and 77 includes the following under steps to take before a therapeutic trial of opioids: baseline pain and functional assessment should be made, and a therapeutic trial should not be employed until the patient has failed a trial of non-opioid analgesics. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The patient's treatment history is limited as only one treatment report dated 10/27/14 is provided for review. It is unclear how long the patient has been prescribed this medication. It was a continuing medication as of 10/27/14. The treater states, the patient states that the symptoms persist but the medications do offer him temporary relief of pain and improve his ability to have restful sleep. He denies any problems with the medications. In this case, it is unclear if use of the medication is short-term or long-term. If the patient recently started Synapryn, the patient is prescribed a non-opioid analgesic (Fanatrex-Gabapentin); however, the treater does not state the patient failed a trial of non-opioid analgesics and no baseline pain or function is documented. The MTUS guidelines require much more thorough documentation of analgesia with before and after pain scales and functional improvements with opioid usage. If use is long-term no specific ADL's are mentioned to show a significant change of use with this medication. Furthermore, opiate management issues are not documented as no UDS's are provided or discussed and there is no discussion of adverse behavior. The request is not medically necessary.