

<b>Case Number:</b>	CM15-0010834		
<b>Date Assigned:</b>	01/28/2015	<b>Date of Injury:</b>	01/14/2009
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2015

### 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: Massachusetts

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:

The injured worker is male patient, who sustained an industrial injury on 01/04/2009. A primary treating office visit dated 11/04/2014 reported subjective complaints of constant, moderate to severe right knee pain that is aggravated with squatting, kneeling, ascending or descending stairs, prolonged sitting, weight bearing, standing and walking. In addition, he complained of numbness, and tingling that radiated to the left foot. The patient reported the medications do help with pain, temporarily allowing him to sleep well. Objective findings showed well healed surgical scars with psoriasis patches scattered over the lower extremities. He is able to perform the heel/toe walk; but with noted right knee pain. The patient is able to squat approximately 20 percent of the normal secondary to pain. There is noted tenderness to palpation over the medial and lateral joint line; along with the patello-femoral joint. There is also tenderness to palpation over the suprapatellar bursa. He is diagnosed with right knee strain/sprain, status post right knee arthroscopy, right knee medical meniscal tear, right knee synovitis and psoriasis. On 01/06/2015 Utilization Review non-certified the following medications: Ketoprofen, Cyclobenzaprine, Tabradol and Deprizine, noting the CA MTUS Chronic Pain Medical Treatment Guidelines was cited. the injured worker submitted an application for independent medical review of the requested services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 5% cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, p111-113 Page(s): 111-113.

**Decision rationale:** The claimant is more than 6 years status post work related injury and continues to be treated for chronic right knee and radiating left leg pain. Cyclobenzaprine is a muscle relaxant and there is no evidence for the use of any muscle relaxant as a topical product. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended.

**Tabradol 1mg/ml 5ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 63-64.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Tabradol Instructions Insert

**Decision rationale:** The claimant is more than 6 years status post work related injury and continues to be treated for chronic right knee and radiating left leg pain. Tabradol is cyclobenzaprine in a FusePaq. compounding kit which is intended for prescription compounding only. In this case, there is no evidence there is a need for medications provided in a compounded or oral suspension formulation. Therefore, Tabradol is not medically necessary.

**Deprizine 15mg/ml, 250 ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 69.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Deprizine Instructions Insert

**Decision rationale:** The claimant is more than 6 years status post work related injury and continues to be treated for chronic right knee and radiating left leg pain. Deprizine is ranitidine hydrochloride in a FusePaq. compounding kit which is intended for prescription compounding only. In this case, there is no evidence that there is a need for medications provided in a compounded or oral suspension formulation. Therefore, Deprizine is not medically necessary.

**Ketoprofen 20% cream:** 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 (1) Medications for chronic pain, p60 (2) Topical Analgesics, p111-112 Page(s): 60, 111-112.

**Decision rationale:** The claimant is more than 6 years status post work related injury and continues to be treated for chronic right knee and radiating left leg pain. Ketoprofen is not currently FDA approved for a topical application and has an extremely high incidence of photocontact dermatitis. In this case, there is no evidence that the claimant has failed a trial of topical diclofenac which could be considered as a treatment option. Therefore, the requested Ketoprofen 20% cream was not medically necessary.