

<b>Case Number:</b>	CM13-0003880		
<b>Date Assigned:</b>	11/06/2013	<b>Date of Injury:</b>	10/07/2002
<b>Decision Date:</b>	01/15/2014	<b>UR Denial Date:</b>	07/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/26/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty certificate in Pain Medicine, and is licensed to practice in Oklahoma and Texas. 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 physician 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 53-year-old male who reported an injury on 10/07/2002. The patient underwent lumbar laminectomy surgery in 09/2003. The patient was treated with an internal bone stimulator, which was removed in 08/2004. The patient continued to have low back pain that was managed with physical therapy, medications, chiropractic care, and epidural steroid injections. The patient's most recent clinical exam indicated that the patient had continued pain rated at a 2/10 radiating into the left lower extremity. Physical findings included positive straight leg raising test on the left, decreased range of motion of the lumbar spine in all planes, minimal tenderness to palpation of the lumbar spine, positive facet loading at the L4-5 bilaterally, and motor strength of the bilateral lower extremities described as 4/5. The patient's diagnoses included status post L5-S1 fusion in 2003, adjacent segment disease at L4-5, facet arthropathy of the lumbar spine, lumbar radiculopathy, and chronic pain. The patient's treatment plan included continuation of medication usage and participation in a home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Temazepam 15mg, #24:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section on Benzodiazepines Page(s): 24.

**Decision rationale:** The clinical documentation submitted for review does indicate that the patient has persistent pain complaints of low back pain with radicular symptoms. The California Medical Treatment and Utilization Schedule does not recommend the long-term use of benzodiazepines such as Temazepam. Guidelines recommend that use be limited to 4 weeks. The clinical documentation submitted for review indicates that the patient has been on this medication for an extended duration. The clinical documentation submitted for review does not provide any evidence of increased functional benefit as a result of this medication. Therefore, continuation would not be supported. As such, the requested Temazepam 15mg, #24 is not medically necessary or appropriate.

**Ketoprofen 20% cream:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar & Thoracic (Acute & Chronic) - Topical NSAIDs

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

**Decision rationale:** The patient does have persistent low back complaints with radicular symptoms. It is noted within the documentation that the patient is intolerant of oral non-steroidal anti-inflammatory medications due to GI upset. However, the California Medical Treatment and Utilization Schedule does not recommend the use of Ketoprofen as a topical agent, as it is not FDA-approved for this type of application. As the patient is intolerant of oral medications, the use of Ketoprofen is not supported by Guideline recommendations. As such, the requested Ketoprofen 20% cream is not medically necessary or appropriate.