

<b>Case Number:</b>	CM14-0155831		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	10/06/2009
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	08/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 Occupational Medicine and is licensed to practice in California. 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 injured worker is a 33-year-old female with a date of injury of October 6, 2009. She was diagnosed with (a) chronic right shoulder pain, status post right shoulder subacromial decompression with rotator cuff repair on October 11, 2012; (b) myofascial pain in the right side of the neck and upper back and (c) chronic lower back pain. In a recent visit note by [REDACTED] dated September 23, 2014 it was indicated that she complained of having some more numbness and tingling sensation in her right last two digits and she felt that they have become intermittently numb. She also complained of persistent right shoulder pain. An examination of the right shoulder revealed tenderness over the lateral and posterior shoulder joint and there was also well-healed scar from arthroscopic surgery. It was also noted that she has significant muscle tension extending into the right upper trapezius muscle and the side of the neck. Range of motion of the right shoulder was decreased by 30% with flexion and abduction and decreased by 20% with internal and external rotations. Medications were prescribed and authorizations for such prescriptions were also requested. This is a review of the requested Ketamine 5% cream 60gram and orphenadrine(Norflex ER) 100mg, #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketamine 5% Cream gr Qty 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics; Ketamine Page(s): 111; 56.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Guidelines indicate that topical analgesics are largely experimental in use with a few randomized control trials to determine their efficacy or safety. The referenced guideline also state that they when one ingredient in a compound carries an unfavorable recommendation, the entire compound is considered to carry an unfavorable recommendation. Further, they are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. As per guidelines, Ketamine is not recommended as there is insufficient evidence to support the use of Ketamine for the treatment of chronic pain and it is still under study. There was no evidence in the medical records submitted that would suggest intolerance to and/or failure of multiple classes of oral agents and/or oral adjuvant medications so as to make a case for usage of topical agents and/or topical compounds which, per the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, are "not recommended." Therefore, the medical necessity of Ketamine cream is not established.

**Orphenadrine-Norflex ER 100mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-sedating muscle relaxants. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines

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

**Decision rationale:** The request for orphenadrine 100 mg #90 is not considered medically necessary at this time. According to the California Medical Treatment Utilization Schedule, non-sedating muscle relaxants are recommended as a second-line option for treatment of acute exacerbations for those with chronic low back pain. From the medical records received for review, while there were objective findings of muscle tension it was noted to be extending into the right upper trapezius muscle and the side of the neck and there was no mention of failure of first-line therapy to substantiate the prescription of second-line medication for the treatment of muscle spasms. More so, it has been noted that the injured worker has been trialed for Flexeril and based in the medical records it was noted to be helpful along side her other medication and as such there is not enough reason to change the prescription from Flexeril to orphenadrine. With all these considerations, the medical necessity of the requested orphenadrine-Norflex 100mg, #90 is not established.