

<b>Case Number:</b>	CM15-0101315		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	10/17/2012
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	04/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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: California

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 51 year old female injured worker suffered an industrial injury on 10/17/2012. The diagnoses included lumbar disc displacement and radiculopathy. The diagnostics included electromyographic studies and lumbar magnetic resonance imaging. The injured worker had been treated with chiropractic therapy, epidural steroid injections and medications. On 3/9/2015, the treating provider reported back pain and right lower extremity. The back pain rated as 8/10 that radiated to the chest with weakness and numbness to the right lower extremity to the toes. There are spasms in the lumbar spine and continued to wear a lumbar corset for support and to reduce pain. She had an impaired gait utilizing a cane for mobility. There were decreased lower extremity sensations. The treatment plan included Cyclobenzaprine, Nortriptyline and container of Ketoprofen 20%.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 7.5 mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 ? 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

**Decision rationale:** Regarding the request for cyclobenzaprine (Flexeril), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested cyclobenzaprine (Flexeril) is not medically necessary.

**Nortriptyline HCL 25 mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R. 9792.20-9792.26 Page(s): 13-16.

**Decision rationale:** Regarding the request for nortriptyline, CA MTUS guidelines state that antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Within the documentation available for review, there is no identification that the medication provides any specific analgesic effect (in terms of reduced numeric rating scale or percent reduction in pain), objective functional improvement, or improvement in psychological well-being. In the absence of clarity regarding those issues, the currently requested nortriptyline is not medically necessary.

**One (1) container of Ketoprofen 20%:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 ? 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for ketoprofen, CA MTUS states that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical ketoprofen is "not currently FDA approved for a topical application. It has an extremely

high incidence of photocontact dermatitis." Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested ketoprofen is not medically necessary.