

<b>Case Number:</b>	CM14-0101989		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	06/28/2002
<b>Decision Date:</b>	06/29/2015	<b>UR Denial Date:</b>	06/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2014

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 48 year old female who sustained an industrial injury on 06/28/2002. The mechanism of injury occurred when she was pulling a 6 foot tall metal rack with wheels and while pulling it over a threshold it and it tipped and tilted to the right hitting the doorway and this yanked her forward, and when she pulled it back upright, it landed on her left hip and shin. In another incident in July of 1997, she was setting up and a 45 pound stainless steel door fell off its hinges and hit her in the head. At that time, she has some herniated discs, with headaches and blurred vision. Diagnoses include cervical spondylosis at C3-C4 and C6-C7 with bilateral upper extremity radiculopathy, left shoulder musculoligamentous sprain/strain, lumbar scoliosis with bilateral extremity radiculopathy, left hip musculoligamentous sprain/strain; left knee internal derangement, rule out meniscus tear, and disc herniation, disc height collapse and stenosis at L3-L4, and L4-L5. Treatment to date has included diagnostic studies, medications, epidural steroid injections, physical therapy, aquatic therapy, and home exercise program. On 05/20/2014 a Magnetic Resonance Imaging, report of the lumbar spine revealed disc desiccation at L2-L3, L3-L4, L4-L5, and L5-S1, and disc protrusion. The present medication regimen includes Celebrex, Prilosec, Tramadol, Norco, Soma, Flexeril and Ibuprophen. A physician progress note dated 06/02/2014 documents the injured worker complains of constant low back pain rated 9 out of 10. She notes her hand feel a lot of pressure-like sensation. Examination of the lumbar spine reveals paraspinal spasm and tenderness. Straight leg raise is positive bilaterally. There is radiating pain in the bilateral lower extremities. Lumbar range of motion is decreased. Lower extremity motor strength testing reveals weakness in the extensor hallucis longus, gastrocnemius and peroneus

longus muscle groups. It is documented that she has had one epidural steroid injection in the past that gave her significant relief for approximately six weeks. She remains temporarily totally disabled, due to back pain. Treatment requested is for 1 One urine drug screen 6/2/2014, Flexeril 10mg #90, Flurbiprofen 20% 120gm, Gabapentin 10% / Cyclobenzaprine 10% / Capsaicin 0.0375%, 120gm, Ketoprofen 20% / Ketamine 10%, 120gm, MRI of the cervical spine, and Soma 350mg #60.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 304.

**Decision rationale:** According to CA MTUS/ACOEM guidelines, a cervical MRI is indicated if unequivocal findings identify specific nerve compromise on the neurologic examination, in patients who do not respond to conservative treatment, and who would consider surgical intervention. Cervical MRI is the mainstay in the evaluation of myelopathy. Per the ODG, an MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, there are no new neurologic findings on physical exam to warrant another MRI study. In addition, it does appear that there have been any attempts at conservative care of the cervical spine. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

**Flexeril 10mg #90:** Upheld

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

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

**Decision rationale:** According to the reviewed literature, Flexeril (Cyclobenzaprine) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the available records show that the patient has not shown a documented benefit or any functional improvement from prior Flexeril use. In addition, there is no clinical indication presented for the chronic or indefinite use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested medication is not medically necessary.

**Soma 350mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Soma (Carisoprodol).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 29, 63.

**Decision rationale:** The CA MTUS does not recommend muscle relaxants, such as Soma (Carisoprodol), for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. No reports show any specific and significant improvements in pain or function because of prescribing muscle relaxants. According to the MTUS guidelines, Soma is categorically not recommended for chronic pain, noting its habituating and abuse potential. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

**Flurbiprofen 20% 120gm:** Upheld

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

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

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. In this case, there is no documentation provided necessitating Flurbiprofen 20% cream. There is no documentation of intolerance to other previous medications. Flurbiprofen, used as a topical NSAID, has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Medical necessity for the requested Fluriprofen 20% cream has not been established. The requested treatment is not medically necessary.

**Gabapentin 10% / Cyclobenzaprine 10% / Capsaicin 0.0375%, 120gm:** Upheld

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

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

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the requested compounded topical agent contains: Gabapentin 10%, Cyclobenzaprine 10%, and Capsaicin 0.0375%. Cyclobenzaprine is not FDA approved for use as a topical application. There is no evidence for the use of any muscle relaxant as a topical agent. In addition, Gabapentin is not recommended as a topical agent per CA MTUS Guidelines. There is no peer-reviewed literature to support its use. . Medical necessity for the requested topical analgesic cream has not been established. The request for the compounded topical analgesic cream is not medically necessary.

**Ketoprofen 20% / Ketamine 10%, 120gm:** Upheld

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

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

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. The requested topical analgesic compound contains: Ketoprofen 20% and Ketamine 10%. Ketoprofen is not currently FDA approved for a topical application, and has an extremely high incidence of photo-contact dermatitis. Medical necessity for the requested topical medication has not been established. The requested topical gel is not medically necessary.

**1 One urine drug screen 6/2/2014:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urinalysis (opiate screening).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Urine drug testing.

**Decision rationale:** According to CA MTUS (2009), a urine drug screen is recommended as an option to assess for the use or the presence of illegal drugs. According to ODG, urine drug testing (UDT) is a recommended tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. In this case, this was not found to be medically necessary. This patient had a previous urine drug screens reported on 1/15/14 and 4/1/14, which did not show any abnormal findings. The proximity of the most recent test to this request was not medically necessary. There was no documentation that the patient was indicated to be anything other than a low risk to require testing more than once or twice per year. Therefore, the request for urine drug testing in 60-90 days was not indicated. Medical necessity of the requested service was not established. The requested urine test was not medically necessary.