

<b>Case Number:</b>	CM13-0027717		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	11/04/2012
<b>Decision Date:</b>	01/22/2014	<b>UR Denial Date:</b>	09/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2013

### 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 Internal Medicine and Cardiology, has a subspecialty in Cardiovascular Disease, and is licensed to practice in 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 43 year old female who reported an injury on 11/04/2012. The mechanism of injury was lifting of a fallen man of the floor. The patient was eventually diagnosed with lumbar spondylosis. The most recent clinical note dated 08/20/2013 reported the patient continued to complain of left lower back pain. Medications included Ibuprofen 800mg 1 tablet three times a day with meals and Cyclobenzaprine Hcl 10mg 1 tablet as needed at bedtime. A physical examination revealed no lumbar deformities, coronal or sagittal imbalance. There was no evidence of swelling, erythema, or ecchymosis. A full range of motion was noted except for painful restricted flexion with normal gait and station. Evaluation of deep tendon reflexes revealed reflexes within normal limits bilaterally. Special testing reported all negative results. There were no noted sensory deficits bilaterally. The patient's motor strength was 5/5 in L2-S1 bilaterally. Physical therapy was deferred, as a daily walking and home exercise program were to continue.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pharmacy purchase of Keto/lido/cap/tram 15% 1% 0.0125% 120ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

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

**Decision rationale:** MTUS Chronic Pain Guidelines state that topical analgesics are "largely experimental in use with few randomized controlled trials to determine efficacy or safety." They are "Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed... Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." There is no documentation provided in the medical records of the patient having neuropathic pain. There is also no clinical information of the patient having any failed first line therapy of antidepressants and/or anticonvulsants. The MTUS Chronic Pain Guidelines state Ketoprofen is not currently FDA approved for a topical application and the only commercially approved topical formulations of lidocaine is Lidoderm patch. Capsaicin is recommended topically only as an option in patients who have not responded or are intolerant to other treatments which has not been documented. Given the above, the request for Keto/Lido/cap/tram 15%/1%/ 0.0012%/5% 120 ml is not medically necessary and appropriate.

**Pharmacy purchase of Flur/cyclo/caps/lid 10%/2%/0.015%/1% 120ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

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

**Decision rationale:** MTUS Chronic Pain Guidelines state that topical analgesics are "largely experimental in use with few randomized controlled trials to determine efficacy or safety." They are "Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed... Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." There is no documentation provided in the medical records of the patient having neuropathic pain. There is also no clinical information of the patient having any failed first line therapy of antidepressants and/or anticonvulsants. MTUS Chronic Pain Guidelines indicate there is no evidence for use of any other muscle relaxant as a topical product. Capsaicin is recommended topically only as an option in patients who have not responded or are intolerant to other treatments and formulations over 0.025% are not supported. The Guidelines also indicate that the only commercially approved topical formulation of lidocaine is the Lidoderm patch. As such, the request for Flur/cyclo/caps/lid 10%/2%/0.015%/1% 120ml is not medically necessary and appropriate.