

<b>Case Number:</b>	CM13-0067102		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	07/01/2008
<b>Decision Date:</b>	05/27/2014	<b>UR Denial Date:</b>	12/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2013

### 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 Orthopedic Surgery 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 claimant is a 47-year-old, female who was injured 07/01/08 sustaining multiple orthopedic injuries, including her low back, bilateral hips, lower extremities, as well as an underlying diagnosis of stress. Clinical records for review include a recent assessment of 10/28/13 with [REDACTED] where the claimant was with primary complaints of low back pain with radiating pain to the left lower extremity. Medical records documented she was status post a previous lumbar L4-5 and L5-S1 fusion from March 2013 with physical examination showing healed incision, no neurologic deficits and a normal gait pattern. Treatment plan at that time was for continuation of medications to include Prilosec, Robaxin, Lortab, multiple topical compounding creams, a gym membership and a one month follow up. Further clinical records in regards to the claimant's medication usage are not noted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ROBAXIN 750 MG QTY: 60.00:** Upheld

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

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

**Decision rationale:** Based on California MTUS Chronic Pain Medical Treatment Guidelines, the continued role of muscle relaxants in this case would not be indicated. A muscle relaxant should be used with caution as second line options for short term symptomatic relief of acute exacerbations in individuals with chronic low back pain. In this instance there is no current indication of acute exacerbation or indication for this second line agent. The request for Robaxin is not medically necessary.

**FLURBIPROFEN 20 % GEL 120 GM QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 2009, Topical Analgesics,NSAIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ,2009, Chronic Pain, Topical Analgesics Page(s): 111-113.

**Decision rationale:** California MTUS Chronic Pain Medical Treatment Guidelines would also not support the role of Flurbiprofen. At present, Guideline criteria only recommends the role of one topical nonsteroidal medication being Diclofenac. The specific request for Flurbiprofen is not supported by Guideline criteria and would not be indicated. The Guidelines indicate that topical compounds are largely experimental with few randomized clinical trials demonstrating their efficacy or safety. Therefore, based on guidelines and a review of the evidence, the request for Flurbiprofen is not medically necessary.

**KETOPROFEN 20%/KETAMINE 10% GEL 120 GM, QTY:1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 2009, Topical Analgesics-Ketoprofen.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 2009, Chronic Pain, Topical Analgesics Page(s): 111-113.

**Decision rationale:** The topical compound containing Ketoprofen and Ketamine also would not be supported. California MTUS Guidelines specifically states that the role of Ketamine is under study with its only recommended for treatment of neuropathic in refractory cases in which all other primary and secondary treatment have been exhausted. Furthermore, it goes on to indicate Ketoprofen is a non-FDA approved agent in the topical setting. It is not recommended due to extremely high incidents of photocontact dermatitis. The specific request for this topical compound that contains a non-FDA approved agent is not medically necessary.

**GABAPENTIN 10%/CYCLOBENZAPRINE 10%/CAPSAICIN 0.0375% 120 GM QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 2009, Pain-Topical Analgesics-Muscle Relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 2009, Chronic Pain, Topical Analgesics Page(s): 111-113.

**Decision rationale:** California MTUS Guidelines also would not support the compound containing Gabapentin, Cyclobenzaprine, and Capsaicin. The role of these agents, particularly Gabapentin would not be indicated. The Guideline criteria indicates that Gabapentin is not recommended with no peer reviewed literature to support its role in the topical setting. Therefore, based on guidelines and a review of the evidence, the request for Gabapentin is not medically necessary.