

<b>Case Number:</b>	CM14-0012216		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	08/20/2012
<b>Decision Date:</b>	08/04/2014	<b>UR Denial Date:</b>	01/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2014

### 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:

This is a 51-year-old female with an 8/20/12 date of injury. She was lifting a box weighing probably more than 20 pounds containing lab supplies and felt a snap and pain in her low back to the lumbosacral level. In an 8/14/13 progress note, the patient complained of severe back and neck pain and has numbness with pins and needles and shooting pain in the right leg. Her activities of daily living are affected. She wakes up in the middle of the night with shooting pain. Objective findings: tender posteriorly in the cervical spine, posterolateral region of the cervical spine, suboccipital region, left suprascapular region, lumbar spine, right lateral hip and right sciatic notch, hyperalgiias in the left little finger and throughout the left upper extremity with pinwheel testing. Diagnostic impression: multiple lumbar disc herniations, lumbar radiculitis/radiculopathy of lower extremities, lumbar paraspinal muscle spasms, sacroiliitis of bilateral sacroiliac joints. Treatment to date: medication management, activity modification. A UR decision dated 1/13/14 denied the requests for Flurbiprofen, Gabapentin, and Cyclobenzaprine creams. Guidelines specifically recommend against the use of each of these agents in a topical cream formulation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MEDS X 3: Flurbiprofen 20% 150gm cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25, 28, 111-113.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. Guidelines do not support the utilization of topical NSAIDs. There was no specific rationale in the reports reviewed to warrant the use of this medication. Therefore, the request for Meds X 3: Flurbiprofen 20% 150 Gm Cream was not medically necessary.

**MEDS X 3: Gabapentin 10% 120gm cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

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

**Decision rationale:** CA MTUS states that topical Gabapentin is not recommended. There is no peer-reviewed literature to support use. A specific rationale identifying why Gabapentin cream would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Meds X 3: Gabapentin 10% 120 Gm Cream was not medically necessary.

**Cyclobenzaprine 10% 120mg cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25, 28, 111-113.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. Cyclobenzaprine is a muscle relaxant and is not supported by guidelines for topical use. A specific rationale identifying why Cyclobenzaprine cream would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Cyclobenzaprine 10% 120mg Cream was not medically necessary.