

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0110425 |                              |            |
| <b>Date Assigned:</b> | 08/01/2014   | <b>Date of Injury:</b>       | 02/19/2008 |
| <b>Decision Date:</b> | 09/09/2014   | <b>UR Denial Date:</b>       | 06/23/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/16/2014 |

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 55-year-old female was reportedly injured on February 19, 2008. The mechanism of injury was not listed in these records reviewed. The most recent progress note was dated June 4, 2014, and indicated that there were ongoing complaints of low back pain. Current medications were stated to include Neurontin, Cymbalta, Senna, and Norco. Medications were stated to provide 80% pain relief as well as improved function. The physical examination demonstrated decreased lumbar spine range of motion and a positive right-sided straight leg raise test. There was decreased sensation in the L4 and L5 dermatomes and weakness with the right toe and ankle. Diagnostic imaging studies of the lumbar spine revealed a disc protrusion at L4-L5 and L5-S1. Previous treatment included epidural steroid injections at L4-L5. A request had been made for flurbiprofen gel, ketoprofen/ketamine gel, and gabapentin/cyclobenzaprine/capsaicin gel and was not certified in the pre-authorization process on June 23, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 20% gel 120 GM.:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 111-112.

**Decision rationale:** The California MTUS guidelines support topical NSAIDs for the short-term treatment of osteoarthritis and tendinitis for individuals unable to tolerate oral non-steroidal anti-inflammatories. The guidelines support 4-12 weeks of topical treatment for joints that are amendable topical treatments; however, there is little evidence to support treatment of osteoarthritis of the spine, hips or shoulders. When noting the injured employee's diagnosis, date of injury and clinical presentation, this request for flurbiprofen cream is not medically necessary.

**Ketoprofen 20%, Ketamine 10 % gel 120 GM.:** Upheld

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

**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.

**Decision rationale:** According to the California Chronic Pain Medical Treatment Guidelines, the only recommended topical analgesic agents are those including anti-inflammatories, Lidocaine, or capsaicin. There is no peer-reviewed evidence-based medicine to indicate that any other compounded ingredients have any efficacy. For this reason, this request for ketamine/ketoprofen gel is not medically necessary.

**Gabapentin 10%, cyclobenzaprine 10%, capsaicin 0.0375% gel 120 GM.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics & Non-steroidal anti-inflammatory drugs (NSAIDs).

**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.

**Decision rationale:** According to the California Chronic Pain Medical Treatment Guidelines, the only recommended topical analgesic agents are those including anti-inflammatories, Lidocaine, or capsaicin. There is no peer-reviewed evidence-based medicine to indicate that any other compounded ingredients have any efficacy. For this reason, this request for gabapentin/cyclobenzaprine/capsaicin gel is not medically necessary.