

<b>Case Number:</b>	CM14-0031570		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	08/08/2012
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	02/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2014

### 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 California and Washington. 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 injured worker is a 42-year-old male who reported an injury on 06/01/2005. The mechanism of injury was not provided within the medical records. The clinical note dated 07/15/2013 is handwritten and largely illegible. The injured worker reported left hip with some improvement on physical examination. The left hip CT scan and x-ray was unremarkable. The left hip with decrease range of motion due to pain, tenderness to palpation at the trochanter. The injured worker's prior treatments have included diagnostic imaging, surgery and medication management. The provider submitted a request for retrospective topical compounds. A Request For Authorization was not submitted for review to include the date the treatment was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for one prescription for Keto/Lido/Dextro 20/10/4%, 420 gm (DOS 10/5/2012): Upheld**

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

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

**Decision rationale:** The request for Retrospective request for one prescription for Keto/Lido/Dextro 20/10/4%, 420 gm (DOS 10/5/2012) is non-certified. The California Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also indicate any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is an agent that is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. The request is not medically necessary.

**Retrospective request for one prescription for Amitrip/Dextro/Trama/Diclo 4/20/5/30%, 240 gm (DOS 10/5/2012): Upheld**

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

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

**Decision rationale:** The request for Retrospective request for one prescription for Keto/Lido/Dextro 20/10/4%, 420 gm (DOS 10/5/2012) is non-certified. The California Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also indicate any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is an agent that is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. The request is not medically necessary.

**Retrospective request for one prescription for Flurbi/Trama/Dextro 30/5/20% (DOS 11/27/2012): Upheld**

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

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

**Decision rationale:** The request for Retrospective request for one prescription for Flurbi/Trama/Dextro 30/5/20% (DOS 11/27/2012) is non-certified. The California Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for

neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also indicate any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen is an NSAID indicated for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment and recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The guidelines also state topical NSAIDS are not recommended for neuropathic pain as there is no evidence to support use. It was not indicated if the injured worker had tried or failed anti-depressants or anti-convulsants. In addition, it was not indicated how long the injured worker had been utilizing this medication. Moreover, there was lack of documentation of efficacy and functional improvement with the use of this medication. Additionally, this medication is for short term use of no greater than 4 to 12 weeks. Furthermore, the request did not indicate a quantity or frequency for this medication. The request is not medically necessary.