

<b>Case Number:</b>	CM14-0050930		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	07/30/2010
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	03/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/21/2014

### 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 Minnesota. 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 57-year-old male who reported an injury on 07/30/2010. The diagnoses included status post anterior/posterior fusion and decompression at L5-S1, anterior cervical fusion, left shoulder arthroscopy, right lower extremity radicular pain, left shoulder rotator cuff syndrome, severe spinal cord compression at C3-4, and status post adjacent level anterior cervical discectomy and fusion at C3-4. Previous treatments included spine surgery, physical therapy, MRIs, and CTs. Within the clinical note dated 06/06/2014, it was reported the injured worker complained of constant postoperative neck pain. He rated his pain 9/10 in severity with radiation into the bilateral upper extremities with associated mild discomfort into the bilateral arms. He complained of constant low back pain rated 8/10 in severity with radiation into the bilateral lower extremities. Medication regimen included Percocet, Soma, and Lyrica. On the physical examination the provider noted the motor exam of the upper extremity is 5/5. The provider indicated the injured worker had a negative Hoffmann sign. The provider requested topical flurbiprofen, Ketamine, and Ketoprofen. However, a rationale was not provided for clinical review. The Request for Authorization was provided and submitted 06/06/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Compound 120GM topical x 30 days, flurbiprofen 20%:** Upheld

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

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

**Decision rationale:** The injured worker complained of postoperative neck pain rated 9/10 in severity with radiation into the bilateral upper extremities associated with mild discomfort into the bilateral arms. He complained of constant low back pain rated 8/10 in severity with radiation into the bilateral lower extremities. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state topical non-steroidal anti-inflammatory drugs (NSAIDs) are indicated for osteoarthritis and tendonitis, in particular that of the knee and elbow and other joints that are amenable to topical treatment. The guidelines recommend topical NSAIDs for short-term use of 4 to 12 weeks. The guidelines note there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. There was a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted does not specify a treatment site. There is a lack of documentation indicating the injured worker had been diagnosed or has signs and symptoms of osteoarthritis or tendonitis. In addition, the request submitted failed to provide the frequency of the medication. The injured worker had been utilizing the medication for an extended period of time since at least 12/2013. Therefore, the request for Compound 120 gm topical times 30 days, flurbiprofen 20% is not medically necessary and appropriate.

**Compound 120GM topical x 30 days, ketoprofen 20%:** Upheld

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

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

**Decision rationale:** The request for compound 120 gm topical x 30 days, ketoprofen 20% is non-certified. The injured worker complained of constant postoperative neck pain rated 9/10 in severity with radiation into the bilateral upper extremities associated with mild discomfort into the bilateral arms. He complained of constant low back pain rated 8/10 in severity with radiation into the bilateral lower extremities. The California Medical Treatment Utilization Schedule (MTUS) Guidelines note Ketoprofen is not currently FDA-approved for topical application as it has an extremely high incidence of photo contact dermatitis. The request submitted failed to provide the frequency of the medication. The request does not specify the treatment site. The guidelines do not recommend the use of Ketoprofen as a topical analgesic. Therefore, the request for compound 120 gm topical times 30 days, Ketoprofen 20% is not medically necessary and appropriate.

**Compound 120GM topical x 30 days, ketamine 10%:** Upheld

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

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

**Decision rationale:** The injured worker complained of postoperative neck pain rated 9/10 in severity with radiation into the bilateral upper extremities associated with mild discomfort into the bilateral arms. He complained of constant low back pain rated 8/10 in severity with radiation into the bilateral lower extremities. California Medical Treatment Utilization Schedule (MTUS) Guidelines note there is a lack of documentation indicating the injured worker is treated for cancer or diagnosed with cancer. There was a lack of documentation indicating the injured worker is being treated for chemotherapy-induced peripheral neuropathy. The documentation provided failed to provide the efficacy of the medication as evidenced by significant functional improvement. The request as submitted did not specify the treatment site. Additionally the guidelines note ketamine is only recommended for treatment of neuropathic pain. There is lack of documentation indicating the injured worker is treated for neuropathic pain. Therefore, the request for compound 120 gm topical times 30 days Ketamine 10% is not medically necessary and appropriate.