

Case Number:	CM14-0061097		
Date Assigned:	07/09/2014	Date of Injury:	02/11/2013
Decision Date:	10/06/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	05/01/2014

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 Rehabilitation & Pain Management has a subspecialty in Interventional Spine 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 patient is a 30-year-old male with date of injury of 02/11/2013. The listed diagnosis per [REDACTED], dated 03/03/2014, is status post L4-L5 microdiscectomy from 09/13/2013. According to this report, the patient complains of intermittent low back pain, rated 1/10 to 2/10, which has remained the same since his last visit. His current medications include tramadol and topical creams which are utilized on an as needed basis. He has been attending physical therapy for 2 to 3 weeks now, which is helping with his pain and range of motion. The objective findings show mild paraspinal spasms and tenderness. Straight leg raising test is negative. Motor strength examination reveals 4/5 in the extensor hallucis longus. All remaining motor groups are 5/5. The utilization review denied the request on 04/14/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound Medication: 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 Topical Analgesics Page(s): 111.

Decision rationale: This patient presents with low back pain. The treating physician is requesting a compound medication flurbiprofen 20% gel 120 g. The 03/03/2014 report shows that the treating physician is requesting a compound cream containing Flurbiprofen 20%, Ketoprofen 20% and Ketamine 10% gel. The MTUS guidelines, page 111, on topical analgesics states that it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS further states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, ketoprofen is currently not approved for topical application. The request is not medically necessary.

Compound medication: Ketoprofen 20% 120gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: This patient presents with low back pain. The treating physician is requesting a compound medication Ketoprofen 20% 120 g. The 03/03/2014 report shows that the treating physician is requesting a compound cream containing Flurbiprofen 20%, Ketoprofen 20% and Ketamine 10% gel. The MTUS guidelines, page 111, on topical analgesics states that it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS further states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, ketoprofen is currently not approved for topical application. The request is not medically necessary.

Compound medication: Ketamine 10% gel 120gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: This patient presents with low back pain. The treating physician is requesting a compound medication Ketamine 10% gel 120 g. The 03/03/2014 report shows that the treating physician is requesting a compound cream containing Flurbiprofen 20%, Ketoprofen 20% and Ketamine 10% gel. The MTUS guidelines, page 111, on topical analgesics states that it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS further states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case,

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