

<b>Case Number:</b>	CM14-0066232		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	07/11/2013
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	05/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/09/2014

### 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:

Injured worker is a male with date of injury 7/11/2013. Per operative report dated 3/19/2014, the injured worker is a 40 year old male who presented with severe back pain, lower extremity radicular pain and failure of maximum non-operative treatments. Physical examination was consistent with positive straight leg raise, weakness in the EHL, tibialis, gastrocs, peroneus longus of 4/5, and decreased sensation to light touch. MRI was consistent with a disc herniation at L4-5 and L5-S1 and severe disc height collapse at L5-S1. Diagnoses included 1) spondylosis, stenosis, disc herniation and severe axial back pain 2) lower extremity radiculopathy 3) failure of maximum non-operative treatments. Surgical procedure was an anterior lumbar radical discectomy and interbody fusion at L4-5 and L5-S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Container of Flurbiprofen 20% Cream, 120 Grams between 4/30/2014 and 6/14/2014.:**  
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 Topical Analgesics section Page(s): 111, 112.

**Decision rationale:** The MTUS Guidelines recommend the use of NSAIDs for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Topical NSAIDs have been shown to be superior to placebo for 4-12 weeks for osteoarthritis of the knee. Topical Flurbiprofen, however, is not FDA approved. The request for 1 Container of Flurbiprofen 20% Cream, 120 Grams between 4/30/2014 and 6/14/2014 is determined to not be medically necessary.

**1 Container of Ketoprofen 20%, Ketamine 10% Cream, 120 Grams between 4/30/2014 and 6/14/2014.: 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 Topical Analgesics section Page(s): 111-113.

**Decision rationale:** The MTUS Guidelines recommend the use of NSAIDs for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Topical NSAIDs have been shown to be superior to placebo for 4-12 weeks for osteoarthritis of the knee. Topical Ketoprofen, however, is not FDA approved. Per MTUS Guidelines, the use of ketamine is not recommended for the treatment of chronic pain. There are no quality studies that support the use of Ketamine for chronic pain, but it is under study for CRPS. Ketamine may offer a promising therapeutic option in the treatment of appropriately selected patients with intractable CRPS. The requesting physician's discussion on the use of this medication, addressing side effects, and the efficacy of its use with this injured worker establishes medical necessity within these guidelines. The use of topical analgesics are recommended by the MTUS Guidelines as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. For this compounded topical analgesic, topical Ketoprofen and topical Ketamine are not recommended, so the entire compounded agent is not recommended.

**1 Container of Gabapentin 10%, Cyclobenzaprine 10%, and Capsaicin 0.0375% Cream 120 Grams between 4/30/2014 and 6/14/2014.: 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 Topical Analgesics section Page(s): 111-113.

**Decision rationale:** The MTUS Guidelines do not recommend the use of topical Gabapentin as there is no peer reviewed literature to support use. The MTUS Guidelines do not recommend the use of topical Cyclobenzaprine as there is no evidence for use. The MTUS Guidelines recommend the use of topical Capsaicin only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of Capsaicin and there are no current indications that this increase over a 0.025% formulation

would provide any further efficacy. The use of topical analgesics are recommended by the MTUS Guidelines as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. For this compounded topical analgesic, all of the active ingredients are not recommended. The request for 1 Container of Gabapentin 10%, Cyclobenzaprine 10%, and Capsaicin 0.0375% Cream 120 Grams between 4/30/2014 and 6/14/2014 is determined to not be medically necessary.