

<b>Case Number:</b>	CM14-0184219		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	09/29/2008
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	10/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2014

### 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. 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 underlying date of injury in this case is 09/29/2008. The date of a physician review under appeal is 10/29/2014. This patient's diagnosis is status post a lumbar fusion of January 2009. On 10/08/2014, the patient was seen in primary treating physician follow-up regarding right leg and low back pain. The patient continued to take Gabapentin and noted slight improvement. The patient was noted to have a history of lumbar fusion in December 2009 with hardware removal August 2013. Overall the patient was felt to have a failed low back syndrome. Treating physician noted the patient had failed medication include anti-inflammatories, topical analgesics, and opioids and had previously tried Flexeril as well. No surgical intervention was felt to be indicated. A spinal cord stimulator trial was suggested. Treatment was recommended to include continued use of Gabapentin as well as a spinal cord stimulator trial and related psychological evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Topical cream: Ketoprofen/Gabapentin/Tramadol:** Upheld

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

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

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines section on topical analgesics, page 111, states that any medication that contains at least one drug that is not recommended is not recommended. This guideline specifically does not recommend Ketoprofen for topical use given an FDA advisory against such an indication. This same guideline also indicates there is no peer-reviewed evidence to support an indication for topical Gabapentin. For these multiple reasons, this overall request is not supported by the treatment guidelines. This request is not medically necessary.

**Prozac 20mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Selective Serotonin Reuptake Inhibitors Page(s): 107.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines section on selective serotonin reuptake inhibitors states that this class of medications is not recommended as a treatment for chronic pain but may have a role in treating secondary depression. The records do not provide an alternate rationale to support an indication or benefit from this class of medications. This request is not supported by the treatment guidelines. Therefore, this request is not medically necessary.