MAXIMUS Federal Services

Case Number:	CM15-0139966		
Date Assigned:	07/29/2015	Date of Injury:	04/27/2010
Decision Date:	09/02/2015	UR Denial Date:	06/25/2015
Priority:	Standard	Application Received:	07/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Hawaii
Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 62 year old female with an April 27, 2010 date of injury. A progress note dated June 2, 2015 documents subjective complaints (intermittent lower back pain rated at a level of 1 to 2 out of 10; occasional radiation to the right lower extremity), objective findings (tenderness to palpation on the paraspinal musculature; tenderness to palpation over the spinous process; decreased range of motion of the lumbar spine; positive straight leg raise test and sacroiliac joint tenderness), and current diagnoses (status post anterior posterior fusion at L4-L5 and L5-S1). Treatments to date have included lumbar spine fusion, medications, imaging studies, and physical therapy. The treating physician documented a plan of care that included Flurbiprofen gel, Ketoprofen gel, and Gabapentin 10%-Cyclobenzaprine 10%- Capsaicin 0.0375%.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for Flurbiprofen 20% gel, 120gm: Upheld

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

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

Decision rationale: The patient presents with intermittent low back pain with occasional radiation to the right lower extremity. The current request is for 1 prescription for Flurbiprofen 20% gel, 120gm. The treating physician requests on 6/2/15 (7B) "Flurbiprofen 20% gel, 120gm" to provide an adjunctive treatment to allow a reduction in the total amount of oral medication required, minimizing the potential side effects of oral medications which have not been well tolerated. MTUS guidelines do not support the usage of Flurbiprofen 20% cream (NSAID) for the treatment of spine, hip, shoulder or neuropathic pain. NSAID topical analgesics are indicated for osteoarthritis and tendinitis of the knee and elbow or other joints that are amenable to topical treatment. This patient presents with lumbar pain for which topical NSAID is not indicated. The current request is not medically necessary.

1 prescription for Ketoprofen 20% 120gm/Ketamine 10% gel 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketamine, topical; Non-FDA-approved agents: Ketoprofen.

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

Decision rationale: The patient presents with intermittent low back pain with occasional radiation to the right lower extremity. The current request is for 1 prescription for Ketoprofen 20% 120gm/Ketamine 10% gel 120gm. The treating physician requests on 6/2/15 (7B) "Ketoprofen 20% 120gm/Ketamine 10% gel 120gm" to provide an adjunctive treatment to allow a reduction in the total amount of oral medication required, minimizing the potential side effects of oral medications which have not been well tolerated. MTUS guidelines state, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The guidelines go further to specifically state that any "Non FDA-approved agents" are not recommended. In this case, we find the compound included, Ketoprofen. Ketoprofen is not currently FDA approved for a topical application as it as an extremely high incidence of photocontact dermatitis. Therefore, any compounded product that contains Ketoprofen is not recommended per MTUS. The current request is not medically necessary.

1 prescription for Gabapentin 10%/Cyclobenzaprine 10%/ Capsaicin 0.0375% 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin, topical; Capsaicin, topical.

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

Decision rationale: The patient presents with intermittent low back pain with occasional radiation to the right lower extremity. The current request is for 1 prescription for Gabapentin

10% / Cyclobenzaprine 10% / Capsaicin 0.0375% 120gm. The treating physician requests on 6/2/15 (7B) "Gabapentin 10% / Cyclobenzaprine 10% / Capsaicin 0.0375% 120gm" to provide an adjunctive treatment to allow a reduction in the total amount of oral medication required, minimizing the potential side effects of oral medications which have not been well tolerated. MTUS guidelines state, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The guidelines go further to specifically state that Gabapentin and Cyclobenzaprine are not recommended as a topical product. The current request is not medically necessary.