

<b>Case Number:</b>	CM14-0149949		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	03/16/2001
<b>Decision Date:</b>	10/17/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2014

### 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 Family Practice and is licensed to practice in Arizona. 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:

Patient is a 41-year-old with a date of injury on March 16, 2001. Diagnoses include failed back surgery, herniated lumbar discs with radiculopathy, chronic neuropathic pain, facet arthropathy, sacroiliitis, and restless leg syndrome. Subjective complaints are of frequent mid back pain rated 6/10 and low back pain rated at 7/10. The pain radiated into the bilateral legs, with numbness and tingling in the right lower extremity. Physical exam shows lumbar spine decreased range of motion, positive straight leg raise test on the right with positive Braggard's and Kemp's tests. Prior treatment includes chiropractic, home exercise, surgery, and medications. Medications include Baclofen, Lyrica, Flurbiprofen gel, ketoprofen/ketamine gel, and gabapentin /cyclobenzaprine /capsaicin gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 20% cream 120gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 112, 113.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicates that topical NSAIDs (non-steroidal anti-inflammatory drugs) have been shown in meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis, but with a diminishing effect over another 2-week period. The Chronic Pain Medical Treatment Guidelines also indicates that topical NSAIDs are not recommended for neuropathic pain as there is no evidence to support their use. The Chronic Pain Medical Treatment Guidelines does indicate that they are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints amenable to topical treatment. Topical NSAIDs have not been evaluated for the spine, hip or shoulder. For this patient, documentation indicates the patient is being treated for back pain. Therefore, the request for Flurbiprofen 20% cream 120 gm is not medically necessary or appropriate.

**Ketoprofen 20% and ketamine 10% cream 120 gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, compounded. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Updated 7/10/14compound drugs

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicates that topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but with a diminishing effect over another 2-week period. CA MTUS also indicates that topical NSAIDs are not recommended for neuropathic pain as there is no evidence to support their use. The Chronic Pain Medical Treatment Guidelines does indicate that they are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints amenable to topical treatment. Topical NSAIDs have not been evaluated for the spine, hip or shoulder. For ketamine, the Chronic Pain Medical Treatment Guidelines indicates that it is understudy and only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Therefore, the request for Ketoprofen 20% and ketamine 10% cream 120 gm is not medically necessary or appropriate.

**Gabapentin 10%, cyclobenzaprine 10% and capsaicin 0.0375% cream 120gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Compound. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (updated 7/10/14)Compounded drugs

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines are clear that if the medication contains one drug that is not recommended the entire product should not be recommended. Guidelines do not recommend topical gabapentin or cyclobenzaprine as no peer-

reviewed literature supports their use. Therefore, the request for Gabapentin 10%, cyclobenzaprine 10% and capsaicin 0.0375% cream 120 gm is not medically necessary or appropriate.