

Case Number:	CM15-0125089		
Date Assigned:	08/04/2015	Date of Injury:	11/29/2010
Decision Date:	09/02/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	06/29/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 55-year-old male who sustained an industrial injury on 11/29/10. Injury occurred when he was standing on a truck ladder and it collapsed, leaving him hanging by his left arm from a bar. He then fell 5 feet to the ground, landing in a seated position. He underwent left shoulder arthroscopic surgery with rotator cuff tear on 2/22/13. The 10/14/14 lumbar spine MRI documented disc desiccation at L2/3 with loss of disc height, a Schmorl's node in the superior endplate of L3, a 3 mm central posterior disc protrusion indenting the thecal sac, facet arthropathy, and mild central canal stenosis. At L4/5, there was mild loss of disc height, a 2 mm central posterior disc protrusion abutting the thecal sac, facet arthropathy, and mild bilateral neuroforaminal stenosis. At L5/S1, there was disc desiccation, mild disc height, and a 5 mm central posterior disc protrusion indenting the thecal sac. Records indicated that the requested topical creams have been prescribed since at least 11/7/14. The 5/11/15 treating physician report cited constant severe low back pain radiating into the lower extremities with associated weakness, numbness and tingling, intermittent moderate bilateral shoulder pain, constant severe right hip pain, and intermittent moderate left hip pain. Current medications included Tylenol #3 and Prilosec. Physical exam documented limited lumbar range of motion, positive nerve tension signs, 4/5 bilateral gastrocnemius and peroneus longus weakness, decreased bilateral S1 dermatomal sensation, and absent bilateral Achilles deep tendon reflexes. Diagnoses included protrusion at L5-S1 with bilateral neuroforaminal stenosis, bilateral S1 radiculopathy, protrusion lumbar spine at L3/4 and L5/S1 with radiculitis/radiculopathy, bilateral hip musculoligamentous sprain/strain, Type III coccyx, and bilateral knee sprain/strain with mild internal derangement.

The treatment plan recommended posterior lumbar interlaminar laminotomy at the bilateral L5/S1 level with associated surgical requests. Authorization was also requested for Flurbiprofen 20% cream 120 gm, Ketoprofen 20% and Ketamine 10% cream 120 gm, and Gabapentin 10%, Cyclobenzaprine 10%, Capsaicin 0.0375% cream 120 gm. These topical medications were prescribed for pain, muscle spasms, and inflammation and to allow a reduction in the total amount of oral medications required. The 6/22/15 utilization review non-certified the requests for Flurbiprofen 20% cream 120 gm, Ketoprofen 20% and Ketamine 10% cream 120 gm, and Gabapentin 10%, Cyclobenzaprine 10%, Capsaicin 0.0375% cream 120 gm as the components of each of these topical creams was not fully guideline supported.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20% cream, 120 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain: Topical analgesics.

Decision rationale: The California MTUS state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines indicate that topical analgesics in general are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Guidelines do not recommend topical non-steroid anti-inflammatory drugs (NSAIDs), like Flurbiprofen, for neuropathic pain or widespread musculoskeletal pain. Guidelines state there is little evidence to utilize topical NSAIDs in the treatment of hip or shoulder osteoarthritis, and no evidence for use in osteoarthritis of the low back. Guidelines also do not recommend topical NSAIDs beyond 12 weeks. The Official Disability Guidelines state that the only FDA approved NSAIDs for topical use is diclofenac. Guideline criteria have not been met. This patient is being treated for back, shoulder, hip, and neuropathic pain. Use of this topical medication has been recommended since at least 11/7/14. There is no compelling rationale presented to support the use of this medication for the documented complaints or current diagnoses, and in the absence of guideline support. Therefore, this request is not medically necessary.

Ketoprofen 20%, Ketamine 10% cream, 120 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain: Topical analgesics.

Decision rationale: The California MTUS guidelines for topical analgesics state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines state that Ketamine is under study and only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. The Official Disability Guidelines state that Ketoprofen is not currently FDA-approved for topical application due to an extremely high incidence of photo contact dermatitis. Guideline criteria have not been met. There is no evidence that this patient has been refractory to all primary and secondary treatment of his neuropathic pain. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request is not medically necessary.

Gabapentin 10%, Cyclobenzaprine 10%, Capsaicin 0.0375%, 120 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain: Topical analgesics.

Decision rationale: The California MTUS guidelines state that if any compounded product contains at least one drug (or drug class) that is not recommended, then the compounded product is not recommended. Guidelines indicate that topical analgesics in general are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical gabapentin is not recommended by the guidelines, as there is no peer-reviewed literature to support use. Guidelines state that there is no evidence for use of a muscle relaxant, such as cyclobenzaprine, as a topical product. Capsaicin 0.0375% is not recommended as there are no current indication that an increase over a 0.025% formulation would provide any further efficacy. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request is not medically necessary.