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| <b>Case Number:</b>   | CM15-0173099 |                              |            |
| <b>Date Assigned:</b> | 09/14/2015   | <b>Date of Injury:</b>       | 05/12/2009 |
| <b>Decision Date:</b> | 11/03/2015   | <b>UR Denial Date:</b>       | 08/18/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/01/2015 |

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 injured worker is a 46 year old female, who sustained an industrial injury on 05-12-2009. The injured worker is currently temporarily totally disabled. Medical records indicated that the injured worker is undergoing treatment for right knee internal derangement, cervical radiculitis, lumbar spine sprain-strain rule out herniated nucleus pulposus, left lower extremity radiculopathy, and left knee sprain-strain. Treatment and diagnostics to date has included negative urine drug screen and use of medications. Current medications include Ibuprofen and topical creams. In a progress note dated 07-27-2015, the injured worker reported constant and moderate low back pain rated 8-9 out of 10 on the pain scale, intermittent and moderate right knee pain rated 5-6 out of 10, and constant and severe left knee pain rated 8-9 out of 10. Objective findings included limited lumbar spine and left knee range of motion, positive straight leg raise test to the left side, positive McMurray's, Steinmann's test, and medial joint line tenderness to the left knee, and sensory deficit noted in the left lower extremity. The request for authorization dated 07-27-2015 requested topical creams and Ibuprofen. The Utilization Review with a decision date of 08-17-2015 certified the request for Ibuprofen 800mg #90 and non-certified the request for Flurbiprofen 20% gel, Ketoprofen 20%, Ketamine 10% gel, and Gabapentin-Cyclobenzaprine-Capsaicin 10-10-0.375%.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Regarding the request for topical flurbiprofen, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there's no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of topical flurbiprofen. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the topical flurbiprofen is for short term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested topical flurbiprofen is not medically necessary.

**Ketoprofen 20% 120gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Regarding the request for topical Ketoprofen, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Ketoprofen is not FDA approved for a topical application. Within the documentation available for review, there's no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of topical Ketoprofen. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the topical Ketoprofen is for short term use, as recommended by guidelines. Additionally, Ketoprofen is not FDA approved for a topical application. In the absence of clarity regarding those issues, the currently requested topical Ketoprofen is not medically necessary.

**Ketamine 10% gel 120gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Ketamine, Topical Analgesics.

**Decision rationale:** Regarding the request for topical ketamine, Chronic Pain Medical Treatment Guidelines state that ketamine is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Within the documentation available for review, there is no indication that all primary and secondary treatment options have been exhausted, neither is there any indication of analgesic efficacy or objective functional improvement as a result of this medication. As such, the currently requested ketamine is not medically necessary.

**Gaba/cyclo/caps 10/10/0.0375% 120gm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Regarding the request for Gaba/cyclo/caps 10/10/0.0375% 120gm, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants drugs are not supported by the CA MTUS for topical use. Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. As such, the currently requested Gaba/cyclo/caps 10/10/0.0375% 120gm is not medically necessary.