

<b>Case Number:</b>	CM13-0071347		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	08/06/2003
<b>Decision Date:</b>	04/28/2014	<b>UR Denial Date:</b>	12/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/27/2013

### 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 patient is a 52-year-old male who reported an injury on 08/06/2003. The mechanism of injury was not provided for review. The patient's treatment history included activity modifications, pain management, epidural steroid injections, lumbar supports, physical therapy, aquatic therapy, and multiple medications. The patient ultimately underwent surgical intervention of a lumbar decompression and fusion at the L4-5. The patient's most recent clinical evaluation documented that the patient had 4/10 to 5/10 pain. The patient's physical findings included restricted range of motion of the lumbar spine secondary to pain, a negative straight leg raising test, and 5/5 lower extremity motor strength. The patient's diagnoses included status post left index finger sprain, left knee status post medial meniscectomy with residual pain, status post lumbar surgery, anxiety and depression, insomnia, status post lateral meniscus repair, GERD secondary to medication, and status post hardware removal and repeat decompression at the L3-4 and L4-5. The patient's treatment plan included continuation of medications, psychiatric support, and continued work restrictions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TOPICAL CREAM WITH GABAPENTIN, TRAMADOL AND KETOPROFEN:** Upheld

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

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

**Decision rationale:** The requested topical cream with Gabapentin, Tramadol, and Ketoprofen is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the use of Gabapentin as a topical analgesic as there is little scientific evidence to support the efficacy of this medication as a topical agent. California Medical Treatment Utilization Schedule does not support the use of Ketoprofen as it is not FDA approved as a topical analgesic. Peer reviewed literature does not support the use of opioids to include tramadol due to lack of scientific evidence to support the efficacy and safety of these medications a topical agents. California Medical Treatment Utilization Schedule states that any compounded medication that contains at least 1 drug or drug class that is not supported by guideline recommendations is not recommended. As such, a topical cream with Gabapentin, Tramadol, and Ketoprofen is not medically necessary or appropriate.