

<b>Case Number:</b>	CM14-0108919		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	10/16/2012
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	07/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in California and Washington. 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 injured worker is a 48-year-old female with a reported date of injury on 10/16/2012. The mechanism of injury was noted to be due to an improperly placed work station. Her diagnoses were noted to include post laminectomy syndrome and status post cervical fusion. Her previous treatments were noted to include medications, neck brace, massage, acupuncture, and physical therapy. The progress note dated 07/14/2014 revealed the injured worker reported pain from her neck radiating to her left upper extremity rated 7 to 8 out of 10. The injured worker reported issues with a magnifier on the job site that increased pain over the previous 4 weeks which affected the left shoulder and arm. The physical examination revealed tenderness throughout trapezius muscles, left and right that extended to the base of the occiput. Her range of motion was limited by pain rated 75% of normal. There was a positive Spurling's to the right side and deep tendon reflexes were 2+ and symmetric. Motor strength was rated optimal bilaterally. The Request for Authorization form was not submitted within the medical records. The request was for Gabapentin 7% / Ketoprofen 10% / Lidocaine 5% compound cream for pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Gabapentin 7% / Ketoprofen 10% / Lidocaine 5% compound cream:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114..

**Decision rationale:** The injured worker has been utilizing compounded cream for neck pain. The California Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. The guidelines primary recommended topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines state the efficacy and clinical trials for topical NSAIDs has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2 week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. In the study, the effect did appear to diminish over time and it was stated that further research was required to determine if results were similar for all preparations. The guidelines state Ketoprofen is a non FDA approved agent. This agent is not currently FDA approved for a topical application. The guidelines recommend lidocaine for localized peripheral pain after there has been evidence of first line therapy (tricyclic, SNRI antidepressants, NSAIDs, such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. The guidelines do not recommend gabapentin for topical use as there is no peer reviewed literature to support use. The guidelines state any compounded agent that contains at least 1 drug (or drug class) that is not recommended is not recommended, and gabapentin and Ketoprofen are not recommended, and lidocaine is only recommended in the Lidoderm patch formulation. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, one (1) prescription of Gabapentin 7% / Ketoprofen 10% / Lidocaine 5% compound cream is not medically necessary.