

<b>Case Number:</b>	CM14-0011460		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	10/06/2011
<b>Decision Date:</b>	06/25/2014	<b>UR Denial Date:</b>	01/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2014

### 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 and Rehabilitation and is licensed to practice in New York and Texas. 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 57 year old male female who sustained injury on 10/06/11 while moving objects. The patient developed complaints of low back pain radiating to the lower extremities with associated numbness. The patient was followed for post-laminectomy syndrome and chronic regional the patient was followed for chronic radiculopathy and chronic regional pain syndrome in the right ankle. The patient was pending a possible spinal cord stimulator trial. Recent epidural steroid injections were completed in 06/13. The last evaluation was from 06/03/13. At this visit the patient continued to report complaints of low back pain radiating to the right lower extremity with persistent swelling at the right ankle. Pain scores were 8/10 on VAS. Medications included ibuprofen, Flector patches, tramadol, Cymbalta, and omeprazole. On physical examination there was continued tenderness to palpation of the lumbar spine with trigger points. Numbness was noted in the right lower extremity consistent with L4 distribution. Range of motion was diminished in the lumbar spine. Weakness on dorsiflexion to the right ankle was also noted. There was allodynia and dyesthesia at the right ankle. Flector patches were continued at this visit and continued use of ibuprofen tramadol and omeprazole. The requested capsaicin cream and topical Ketoprofen gabapentin compound were both denied by utilization review on 01/28/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CAPSAICIN CREAM:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS,

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

**Decision rationale:** In regards to the requested capsaicin cream, this topical analgesic would not be supported as medically necessary based on the very limited clinical information provided for review. The last pain management consult available for review was from June of 2013. At this time the patient was utilizing Flector patches. Capsaicin can be considered an option in the treatment of neuropathic pain when standard oral medications such as antidepressants and anticonvulsants have failed to address symptoms. In this case there is no indication that the patient has failed a reasonable trial of antidepressants or anticonvulsants to address right lower extremity pain in the 06/13 clinical record. No other further clinical evaluations were available for review providing further information to support the use of this cream as medically appropriate. Therefore this reviewer would not have recommended certification for the request.

**KETOPROFEN/GABAPENTIN COMPOUND:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS,

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

**Decision rationale:** In regards to the requested ketoprofen/gabapentin compounded cream, this topical analgesic would not be supported as medically necessary based on the very limited clinical information provided for review. The last pain management consult available for review was from June of 2013. At this time the patient was utilizing Flector patches. Topical analgesics can be considered an option in the treatment of neuropathic pain when standard oral medications such as antidepressants and anticonvulsants have failed to address symptoms. In this case there is no indication that the patient has failed a reasonable trial of antidepressants or anticonvulsants to address right lower extremity pain in the 06/13 clinical record. No other further clinical evaluations were available for review providing further information to support the use of this cream as medically appropriate. Furthermore, neither ketoprofen nor gabapentin are FDA approved for transdermal use. Therefore this reviewer would not have recommended certification for the request.