

Case Number:	CM14-0013674		
Date Assigned:	06/11/2014	Date of Injury:	07/16/1996
Decision Date:	07/14/2014	UR Denial Date:	01/20/2014
Priority:	Standard	Application Received:	02/03/2014

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 Illinois. 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 75 year old male who reported an injury of unknown mechanism on 07/16/1996. On 01/11/2014 his chief complaint was low back pain and spasms. There were 40 degrees of flexion and 10 degrees of extension noted. A straight leg raise was positive for pain. Ankle dorsi and plantar flexors were 5/5. Quadriceps and ilipsoas were 5/5. His medications include tramadol 50 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

KGL CREAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesic guidelines Page(s): 111-113.

Decision rationale: On 01/11/2014 the chief complaint was low back pain and spasms. KGL cream contains ketoprofen, gabapentin and lidocaine. CA MTUS guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages

that include lack of systemic side effects, absence of drug interactions and no need to titrate. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photo-contact dermatitis. Gabapentin is not recommended. Lidocaine is indicated for localized neuropathic pain after failure of trials with oral tricyclic or SNRI antidepressants or an AED such as gabapentin, but only in patch form. Only FDA approved products are currently recommended. Additionally, there is no dosage or directions for use included with the request. Therefore, the request for KGL cream is not medically necessary.