

Case Number:	CM14-0019852		
Date Assigned:	02/21/2014	Date of Injury:	03/09/2008
Decision Date:	07/24/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/18/2014

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 Occupational Medicine and is licensed to practice 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:

This is a 52-year-old female with a date of injury of 3/9/08. The mechanism of injury was not noted. In a progress note dated 5/2/11, the patient presented with pain in the neck, which was described as dull, aching, throbbing, sharp in quality, and dependent upon activity. The pain radiated to the head, bilateral shoulders, bilateral hands, down to the low back and right knee with complaints of numbness and tingling in the neck with reports of weakness. The pain was partially relieved by resting, massaging the area, changing positions, applying medicated ointment, and taking medication. Physical examination revealed tenderness to palpation and decreased sensation to pinprick and light touch of the posterior aspect of the arm. Diagnostic impression: right shoulder sprain, rule out tear and impingement. Treatment to date: medication management, activity modification, physical therapy. A prior Utilization Review decision dated 1/31/14 did not grant the retrospective request for Lidocaine/Ketoprofen/Gabapentin for the treatment of right shoulder strain. The clinical information provided does not establish the medical necessity of this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REQUEST FOR MEDICATIONS
LIDOCAINE/KETOPROFEN/GABAPENTIN (DURATION UNKNOWN AND
FREQUENCY UNKNOWN) DISPENSED 4/27/11 FOR TREATMENT OF RIGHT
SHOULDER STRAIN: Upheld**

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25, 28, 111-113.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In addition, The California MTUS states that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). There is no documentation that the patient has ever been on a first-line agent. In addition, lidocaine in a topical cream form is not recommended because the dose is not easily controlled and continued use can lead to systemic toxicity. Ketoprofen is not currently FDA approved for topical application. It has an extremely high incidence of photocontact dermatitis. Guidelines do not recommend Gabapentin for topical application. There was no clear detail provided in the available documentation of the necessity for this compound topical medication and why the patient could not use over-the-counter topical treatment. Also, the use of prescription topical/compounded analgesics is unproven as an effective treatment alternative for long-term pain relieve and not supported by guidelines. Therefore, the request for retrospective request for medications Lidocaine/Ketoprofen/Gabapentin (Duration Unknown And Frequency Unknown) dispensed 4/27/11 for treatment of right shoulder strain was is medically necessary.