

<b>Case Number:</b>	CM14-0116618		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	04/12/2013
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	07/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2014

### 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 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 48-year-old male who reported an injury on 04/12/2013. The mechanism of injury was noted to be a slip and fall. The documentation submitted states the injured worker had a diagnoses of surgical fusion at C4-5 and C6-7 with continued lumbar radiculopathy, sprain to the shoulder/right hand, chronic headaches, and lumbar stenosis. He had prior treatments including medications and physical therapy. He was noted to have diagnostic image studies. The injured worker has surgical history of spinal surgery. The injured worker had subjective complaints of neck pain rated a 7/10, with radiation to the bilateral upper extremities. He also complained of constant bilateral shoulder pain, rated 7/10. In addition he had complaints of constant low back pain, rated 7/10 with radiation to the bilateral lower extremities down to the feet, with an associated burning sensation. The physical examination noted decreased range of motion, weakness of the wrist extensors bilaterally. Examination of the lumbar spine revealed positive straight leg raise test bilaterally with radiating pain in the bilateral lower extremities. There was neurogenic claudication with ambulation. The treatment plan was for medication refills. The rationale for the request was noted within the treatment plan. A Request for Authorization form was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 10%/cyclobenzaprine 10%/ Capsaicin 0.0375% cream 120 gm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): Pages 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** The request for Gabapentin 10%/cyclobenzaprine 10%/ Capsaicin 0.0375% cream 120 gm is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines state "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These are 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. Many of these agents are compounded as monotherapy or in combination for pain control. 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 use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The requested medication contains gabapentin." The guidelines do not recommend topical gabapentin; there is no peer reviewed literature to support its use. Therefore, according to the guidelines the entire medicated cream is not recommended. In addition, the provider's request fails to indicate a dosage frequency. Therefore, the request for Gabapentin 10%/cyclobenzaprine 10%/ Capsaicin 0.0375% cream 120 gm is not medically necessary.