

Case Number:	CM14-0172826		
Date Assigned:	10/23/2014	Date of Injury:	03/04/2002
Decision Date:	12/02/2014	UR Denial Date:	10/17/2014
Priority:	Standard	Application Received:	10/20/2014

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 Neurology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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:

4/8/14 note indicates pain condition of back pain, with back stiffness, numbness in the left leg and radicular left leg pain. The pain is described as aching, burning, sharp, throbbing, with pain down the legs. Pain is 6-7/10. The insured had a back fusion 3 months prior and has 30% improvement in pain. Medications were indicated as Ativan, Flexeril, Gabapentin, Inderal, Methadone, Norco, and Zanaflex. Examination noted hip flexors and quadriceps bilateral were 4/5. 10/3/14 note indicates pain condition of back pain, with back stiffness, numbness in the left leg and radicular left leg pain. The pain is described as aching, burning, sharp, throbbing, with pain down the legs. Examination noted hip flexors and quadriceps bilateral were 4/5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin/Ketoprofen/Lidocaine 7/10/5% Cream 240 Gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Cream Page(s): 111.

Decision rationale: MTUS guidelines support that topical pain preparations are "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have

failed." The medical records provided for review indicate a pain condition related to neurological condition but does not detail previous trials of antidepressants or anticonvulsants tried and failed or demonstrated to be intolerant. As such the medication records do not support the use of topical compound cream at this time as medically necessary.