

<b>Case Number:</b>	CM14-0044434		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	11/17/2012
<b>Decision Date:</b>	08/26/2014	<b>UR Denial Date:</b>	03/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/11/2014

### 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 California and Washington. 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 33-year-old female who reported an injury on 11/17/2012; the mechanism of injury was described as the injured worker slipping and falling. Within the clinical visit on 04/10/2014, it was noted that the injured worker complained of thoracic and right intercostal pain that she reported 5/10 to 6/10. Current medications were noted to be Motrin as needed with dosages and frequency not provided. Pertinent surgical history was not provided within the submitted medical records. Diagnostic studies were not provided within the submitted medical records. It was further noted in the report that the patient had been approved for a greater trochanteric injection and approved for aquatic physical therapy. Within the physical exam it was noted that peripheral pulses are 2+ bilaterally with normal capillary filling and the bilateral lower extremities range of motions were restricted in all directions. Cervical and lumbar range of motions were restricted secondary to pain. The patient's diagnoses were listed as left greater trochanter bursitis, left hip pain, right thoracic facet joint pain, thoracic facet joint arthropathy, right intercostal sprain/strain, thoracic sprain/strain, lumbar sprain/strain, and cervical sprain/strain. It was noted in the treatment plan that the physician was appealing the denial of a recent request for Gabapentin/Ketoprofen/Lidocaine cream in which the direct active ingredients composition was listed as 7%, 10%, and 5% of the active ingredients. The request for authorization was dated 04/10/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketoprofen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation ODG Pain, Compound drugs.

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

**Decision rationale:** The request for Ketoprofen is not medically necessary. The California MTUS Guidelines state for topical analgesics any compounded cream in which any part of the compounded cream is not recommended, the compound as a whole is not recommended. The California MTUS Guidelines recommend that topical NSAIDS have been inconsistent in most studies and are small and of short duration and was shown that topical NSAIDS to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with diminishing effects over another 2 week period. Indications for usage are osteoarthritis and tendonitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment. It is recommended that a short-term use of topical NSAIDS (4 to 12 weeks) would be indicated. There is little evidence to utilize topical NSAIDS for treatments of osteoarthritis of the spine, hip, or shoulder and is not recommended for neuropathic pain. In the submitted medical records, it was shown that there was a compounded cream that contained Ketoprofen. However, the request in itself does not specifically identify the delivery of Ketoprofen nor its indicated usage, dosage, or frequencies provided and cannot be supported at this time by the guidelines. Furthermore, through the documentation there is no indicated usage if this was in fact a cream indicated to be compounded. As such, the request for Ketoprofen is not medically necessary.

**Lidocaine cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official disability Guidelines, compound drugs.

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

**Decision rationale:** The request for Lidocaine cream is not medically necessary. The California MTUS Guidelines state that Lidocaine is recommended for neuropathic pain after there has been evidence of a trial of first line therapy. Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also off labeled use for diabetic neuropathy with no other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Within the request itself it is not indicated that this is part of the compounded cream as evidenced through the request for authorization; however, the delivery system is through a cream and is not recommended by the guidelines. The only form of recommended Lidocaine is through the dermal patch system (Lidoderm). With the direct non-recommendation of Lidocaine cream

and the current request as presented, it is not supported by the guidelines at this time. As such, the request for Lidocaine cream is not medically necessary.

**Gabapentin:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official disability Guidelines, compound drugs.

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

**Decision rationale:** The request for Gabapentin is not medically necessary. The California MTUS Guidelines state that for any compounded product that contains any 1 ingredient that is not recommended by the guidelines, the compound as a whole is not recommended. The California MTUS Guidelines state that Gabapentin is not recommended as there is no peer-reviewed literature to support its use. It is unclear if this is part of the compounded cream as requested through the request for authorization. However, the request in itself does not provide the frequency, dosages, or the intended delivery system of the request. Given that the request for authorization is for a topical application, the request for Gabapentin is specifically not recommended by the guidelines and is not supported at this time. As such, the request for Gabapentin is not medically necessary.