

<b>Case Number:</b>	CM14-0062640		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	10/15/2012
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	04/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2014

### 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 in 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:

The patient is a 35 year old male who has submitted a claim for cervical sprain/strain and radiculopathy, right shoulder internal derangement, left foot and heel sprain and plantar fasciitis, and pain related insomnia; associated with an industrial injury date of 10/15/2012. Medical records from 2013 to 2014 were reviewed and showed that patient complained of neck and right shoulder pain, graded 7-9/10, and headaches. Active range of motion and walking cause pain. Physical examination showed moderate to severe tenderness of the cervical spine and right shoulder. Range of motion was decreased. Treatment to date has included medications and physical therapy. Utilization review, dated 04/18/2014, denied the request for KGL cream because there was no evidence of failed trials of first-line oral antidepressants and anticonvulsants to warrant use of topical medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**KGL cream: Keto/Gaba/Lid 15/10/10%, Quantity 1 month Supply + one refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : Topical analgesics Page(s): 111-113.

**Decision rationale:** As stated on pages 111 to 113 of the MTUS Chronic Pain Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are recommended as an option for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Regarding Ketoprofen, the only topical NSAID formulation supported in the MTUS Chronic Pain Guidelines is Diclofenac. Regarding the Gabapentin component, the MTUS Chronic Pain Guidelines do not recommend it as there is no peer-reviewed literature to support its use. Regarding the lidocaine component, the MTUS Chronic Pain Guidelines recommend its use for neuropathic pain after a trial of oral first-line agents such as antidepressants or anticonvulsants. In this case, the patient complains of neck and right shoulder pain despite medications and physical therapy. However, medical records reviewed did not show failure of oral formulations. Moreover, topical use of all the components of the topical compound is not recommended. Therefore, the request is not medically necessary and appropriate.