

<b>Case Number:</b>	CM14-0199339		
<b>Date Assigned:</b>	12/09/2014	<b>Date of Injury:</b>	06/01/2012
<b>Decision Date:</b>	01/26/2015	<b>UR Denial Date:</b>	11/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2014

### 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 Rehab, has a subspecialty in Interventional spine 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 45-year-old female with a date of injury of 06/01/2012. According to the progress report dated 11/06/2014, the patient presents with continued low back pain and lower extremity pain with numbness, right greater than left. She also states that her upper back is "bothersome." The patient's treatment history includes physical therapy, acupuncture, chiropractic treatment, and medications. Current medications are Tramadol ER for pain and gabapentin for neuropathic pain. The patient also utilizes Laxacin as needed for medication-induced constipation. Physical examination of the lumbar spine revealed moderate bilateral lumbar paraspinal muscle with 1 to 2+ muscle spasms. Range of motion is decreased in all planes. Examination of the lower extremity revealed positive straight leg raise bilaterally at 30 degrees. There is tenderness over the medial aspect of the left knee. The listed diagnoses are: 1. Lumbar radiculopathy, bilateral lower extremity. 2. Lumbar spine sprain/strain with 3-mm disk protrusion at L4-L5 with evidence of annular fissure. Treatment plan is for refill of medications, Dendracin lotion for the patient's neuropathic pain and KGL compounded rub for treatment of neuropathic pain. The Utilization Review denied the request for the topical lotions on 11/17/2014. Treatment reports from 05/06/2014 to 11/06/2014 were reviewed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Dendracin lotion (unspecified QTY and strength): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-topical analgesics

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Page(s): 111.

**Decision rationale:** This patient presents with continued low back pain and lower extremity pain with numbness, right greater than left. The current request is for Dendracin lotion (unspecified QTY and strength). Dendracin lotion is a compound topical cream that includes methyl salicylate 30%, capsaicin 0.025%, and menthol 10%. The MTUS Guidelines page 111 has the following regarding topical creams, "Topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety." In this case, methyl salicylate topical, an NSAID, is supported for peripheral joint arthritic and tendinitis type of problems only. This patient presents with low back pain for which topical NSAID is not indicated. This request is not medically necessary.

**KGL (Ketoprofen, Gabapentin and Lidocaine) cream #240gm:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- topical analgesics

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Page(s): 111.

**Decision rationale:** This patient presents with continued low back pain and lower extremity with numbness, right greater than left. The current request is for KGL (ketoprofen, gabapentin, and lidocaine) cream #240 g. The MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." Under Ketoprofen, MTUS states, "This agent is not currently FDA approved for a topical application." Furthermore, Gabapentin is not recommendation in any topical formulation and lidocaine is only allowed in a patch form. This topical compound medication is not medically necessary.