

<b>Case Number:</b>	CM14-0206036		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	08/07/2012
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	11/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabn, Pain Management

### 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 40 year-old female with an original date of injury on 3/7/2012. The injury occurred when the patient was lifting a 50 lb sac that resulted in right shoulder pain. The industrially related diagnoses are cervical disc disease, lumbar disc disease, status post right elbow lateral epicondylar release, right wrist triangular fibrocartilage complex tear secondary to instability, carpal tunnel syndrome, right shoulder arthroscopy and rotator cuff repair on 2/28/2014. A left shoulder MRI from 2/28/2014 showed mild rotator cuff tendinitis with no tear, minimal hypertrophic changes of AC joint, and mild scaring of rotator cuff interval indicative of chronic capsulitis. The treatments to date include cortisone injection, physical therapy, Norco, cyclobenzaprine, omeprazole, tramadol, TGHOT (tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%, Capsaicin 0.05%), and topical FCL (flurbiprofen 20%, cyclobenzaprine 4%, Lidocaine 5%). The disputed issue is the request for Ketoprofen 15% Lidocaine 5% and cyclobenzaprine 2% topical treatment. A utilization review dated 11/10/2014 has non-certified this request. The stated rationale for denial was there was no indication of intolerance to oral medication that the patient needs alternative treatment in the form of a topical analgesic. In order for this medication to be considered for certification, evidence of measurable subjective and or functional benefit as a result of the medication and documentation of medical necessity including failed trials of anticonvulsants and antidepressants will be required. Based on the submitted documentation, this request is non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CMPD: Ketoprofen 15% Lidocaine 5% Cyclobenzaprine 2%:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines on page 112 state the following: "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. (Diaz, 2006) (Hindsen, 2006) Absorption of the drug depends on the base it is delivered in. (Gurol, 1996). Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. (Krummel 2000)" The documentation provided did not show evidence of intolerance or failure of oral NSAIDs nor any benefit from previous use of Flurbiprofen 20%. Given this information, this request is not medically necessary. Regarding request for topical lidocaine, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines go on to state that no commercially approved topical formulations of lidocaine cream, lotion, or gel are indicated for neuropathic pain. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Furthermore, the patient has been using topical Lidocaine without documented improvement. Lastly, guidelines do not support the use of topical lidocaine preparations, which are not in patch form. As such, the currently requested Lidocaine topical treatment is not medically necessary. Regarding the request for topical cyclobenzaprine, Chronic Pain Medical Treatment Guidelines state that topical muscle relaxants are not recommended. They go on to state that there is no evidence for the use of any muscle relaxants as a topical product. The patient has been using a topical formulation containing cyclobenzaprine for over 6 months without documented improvement of symptom or function. Therefore, the currently requested topical cyclobenzaprine is not medically necessary.