

<b>Case Number:</b>	CM14-0139575		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	09/22/2006
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	08/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2014

### 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 Internal Medicine and is licensed to practice in California and Illinois. 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 51-year-old female who reported an injury on 09/22/2006. The mechanism of injury was not provided within the medical records. The clinical note dated 05/20/2014 indicated diagnoses of post laminectomy syndrome of lumbar region, degeneration of cervical intervertebral discs, and degeneration of lumbar or lumbosacral intervertebral discs. The injured worker reported no treatment authorization since last visit and she had not received her ankle-foot orthoses for her right leg. She reported her low back pain 8/10 post laminectomy syndrome. The injured worker reported there had been no change in her physical examination. The injured worker reported at the posterior left lower back, posterior right lower back, posterior right buttocks, posterior right upper leg, posterior right knee, posterior right lower leg, posterior right ankle, posterior right foot, right lower leg, right ankle, right foot, and right knee with tenderness on the posterior right buttocks, posterior left lower back, posterior left buttocks, posterior right upper leg, posterior right knee, posterior right lower leg, posterior right ankle, posterior right foot, right lower leg, right ankle, and right foot. The injured worker reported limitation using legs and feet while bending, climbing, crawling, and reaching, running, lifting over 5 pounds, and sitting over 30 minutes. The injured worker reported pain in legs, back, and feet while bending, climbing, crawling, running, reaching, sitting over 30 minutes. The injured worker reported pain that radiated into the lumbar back, the posterior thigh, the hip, the calf, and the heel on the right. The injured worker indicated that her severity is chronic and moderate to severe. The severity of the injured worker's symptoms interferes daily with her normal lifestyle, routine daily activities, work and sleeping. The injured worker indicated that her pain level was 9 on a scale of 1 to 10. The injured worker reported her pain was constant. The injured worker reported leg cramps which occasionally happened during the day. The injured worker reported she had not returned to work. On physical examination, the injured worker's motion of the neck

was limited by pain. The injured worker ambulated with an antalgic gait. The injured worker's treatment plan included an Electromyography (EMG). The injured worker's prior treatments included diagnostic imaging, surgery, and medication management. The injured worker's medication regimen included Alprazolam, Cyclobenzaprine Gabapentin, Hydrocodone/Acetaminophen, Prilosec and Ultram ER. The provider submitted a request for topical compound creams. A Request for Authorization was not submitted for review to include the date the treatment was requested.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Retrospective request for Gabapentin 7%, Ketoprofen 10%, Lidocaine 5% (DOS: 05/20/2014): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request for Retrospective request for Gabapentin 7%, Ketoprofen 10%, Lidocaine 5% (DOS: 05/20/2014) is not medically necessary. The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. It was not indicated if the injured worker had tried and failed antidepressants or anticonvulsants. In addition, Gabapentin is not recommended. There is no peer review literature to support its use. Moreover, Ketoprofen is not currently FDA approved for topical application. In addition, Lidocaine is approved in the dermal patch Lidoderm. No other creams, lotions or gels are approved for neuropathic pain. Any compounded product that contains at least one drug, or drug class, that is not recommended is not recommended. In addition, the request does not indicate a dosage, frequency, or quantity. Furthermore, the provider did not indicate a rationale for the request. Therefore, the request is not medically necessary.

**Retrospective request for Ketoprofen 10%, Cyclobenzaprine 3%, Capsaicin 0.0375%, Menthol 2% Camphor 1% (DOS: 05/20/2014): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request for Retrospective request for Ketoprofen 10%, Cyclobenzaprine 3%, Capsaicin 0.0375%, Menthol 2% Camphor 1% (DOS: 05/20/2014) is not medically

necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. It was not indicated if the injured worker had tried and failed antidepressants or anticonvulsants. In addition, Ketoprofen is not currently FDA approved for topical application. Additionally, Cyclobenzaprine is not recommended as a topical muscle relaxant as there is no evidence for the use of any other muscle relaxers as topical products. Furthermore, Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. It was not indicated that the injured worker was intolerant to other treatments. Moreover, Capsaicin comes in the formulation of 0.025%. The formulation of 0.0375% is excessive. Furthermore, the request does indicate a frequency, dosage, or quantity. Additionally, the provider did not indicate a rationale for the request. Therefore, the request is not medically necessary.