

Case Number:	CM15-0025995		
Date Assigned:	02/18/2015	Date of Injury:	05/04/2010
Decision Date:	04/03/2015	UR Denial Date:	01/21/2015
Priority:	Standard	Application Received:	02/11/2015

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: New York, Tennessee
 Certification(s)/Specialty: Emergency Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 67 year old male sustained an industrial injury on 5/4/10. He subsequently reports ongoing neck, right shoulder and low back pain. Diagnoses include cervical and lumbar radiculopathy with DDD and spondylosis and shoulder osteoarthritis. Treatments to date have included prescription pain medications. On 1/21/15, Utilization Review non-certified a request for Ketaprofen 10% / Diclofenac 10% / Gabapentin 10% / Lidocaine 5%, compound. The Ketaprofen 10% / Diclofenac 10% / Gabapentin 10% / Lidocaine 5%, compound was denied based on MTUS Chronic Pain guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketaprofen 10% / Diclofenac 10% / Gabapentin 10% / Lidocaine 5%, compound: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 111-112.

Decision rationale: This medication is a topical analgesic containing ketoprofen, diclofenac, gabapentin, and lidocaine. Topical analgesics are recommended for neuropathic pain when anticonvulsants and antidepressants have failed. Compounded topical analgesics are commonly prescribed and there is little to no research to support the use of these compounds. Furthermore, the guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Absorption of the drug depends on the base it is delivered in. 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. It is not recommended. Diclofenac is a topical non-steroidal anti-inflammatory drug (NSAID). Topical NSAIDs have been shown to be superior to placebo in the treatment of osteoarthritis, but only in the short term and not for extended treatment. The effect appears to diminish over time. Absorption of the medication can occur and may have systemic side effects comparable to oral form. It is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case the patient is diagnosed with osteoarthritis of the right shoulder, but there are no imaging studies to support the diagnosis. Diclofenac has not been studied for the shoulder. It is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA approved for the treatment of post-herpetic neuralgia. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. In this case the patient's pain is not localized. It is not recommended. This medication contains drugs that are not recommended. Therefore the medication cannot be recommended. The request should not be authorized.