

<b>Case Number:</b>	CM13-0015344		
<b>Date Assigned:</b>	03/26/2014	<b>Date of Injury:</b>	01/21/2009
<b>Decision Date:</b>	05/12/2014	<b>UR Denial Date:</b>	08/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2013

### 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 & Rehabilitation and Pain Medicine, and is licensed to practice in Texas and Ohio. 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 47-year-old male who reported an injury on 01/21/2009. The mechanism of injury was not provided for review. The injured worker was evaluated on 07/16/2013. It was documented that the injured worker had a significant increase in left lower lumbar spine pain. Physical findings included tenderness to palpation of the paralumbar musculature with spasms and limited range of motion secondary to pain. The injured worker's diagnosis included multilevel disc bulging of the lumbar spine. The injured worker's treatment plan at that time included the use of a back brace and TENS unit in combination with transdermal creams and medications for pain control. This was the most recent clinical evaluation submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TOPICAL EXOTEN-C LOTION 0.002/10/20% #11.4ML:** Upheld

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

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

**Decision rationale:** The requested topical Exoten-C lotion 0.02/10/20%, #11.4 mL is not medically necessary or appropriate. The requested medication is a compounded topical analgesic

that contains methyl salicylate, menthol, and capsaicin. California Medical Treatment Utilization Schedule recommends the use of methyl salicylate and menthol in the management of osteoarthritic-related pain. California Medical Treatment Utilization Schedule recommends capsaicin as a topical analgesic when the injured worker has failed to respond to all first-line chronic pain treatment modalities. The clinical documentation submitted for review does not provide any evidence that the patient has not had significant pain relief from first-line medications to include antidepressants and anticonvulsants. Therefore, the use of capsaicin as a topical agent would not be supported. California Medical Treatment Utilization Schedule states that any medication that contains at least 1 drug or drug class that is not supported by guideline recommendations is not recommended. Also, the request as it is written does not specifically identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested topical Exoten-C lotion 0.02/10/20% #11.4 mL is not medically necessary or appropriate.

**TOPICAL GABAKETOLIDO 6/20/6, 15% #240GM:** Upheld

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

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

**Decision rationale:** The requested topical gaba keto lido is not medically necessary or appropriate. The requested medication contains gabapentin, Ketoprofen, and lidocaine in a topical cream formulation. California Medical Treatment Utilization Schedule does not recommend the use of gabapentin as a topical analgesic as there is little scientific data to support the efficacy and safety of this type of medication. Additionally, California Medical Treatment Utilization Schedule does not recommend the use of Ketoprofen as a topical analgesic as it is not Food and Drug Administration (FDA)-approved in this formulation. California Medical Treatment Utilization Schedule does not recommend the use of lidocaine in a cream or gel formulation as it is not FDA-approved to treat neuropathic pain. Also, the request as it is submitted does not identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested topical gaba keto lido 6/20/6, 15% #240 gm is not medically necessary or appropriate.