

<b>Case Number:</b>	CM13-0043196		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	08/28/2009
<b>Decision Date:</b>	04/24/2014	<b>UR Denial Date:</b>	10/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2013

### 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 Occupational Medicine, 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 applicant is a represented [REDACTED] employee, who has filed a claim for chronic low back pain and chronic pain syndrome associated with an industrial injury sustained on August 28, 2009. Thus far, the applicant has been treated with analgesic medications, transfer of care to and from various providers in various specialties, and topical compounded agents. An October 22, 2013 progress note states that the applicant reports persistent chronic neck and low back pain. The applicant is asked to consult a pain management physician to consider cervical and/or epidural steroid injections. The applicant was described as permanent and stationary. It does not appear that the applicant was working with permanent restrictions in place. In an October 1, 2013 note, the applicant was given a Toradol injection in the clinic setting for chronic neck and low back pain. It was stated that the applicant was off of work and had not returned to work since the date of the injury. On this visit, it was stated that the applicant was not presently taking any medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**120 GMS OF COOLEEZE GEL (MENTHOL 3.5%, CAMPHOR 0.5%, CAPSAICIN 0.008%, HYALURONIC ACID 0.2%) WITH FOUR REFILLS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Page(s): 111.

**Decision rationale:** As noted in the MTUS-Adopted ACOEM guidelines, oral pharmaceuticals are a first-line palliative method. In this case, there is no evidence of intolerance to and/or failure of multiple classes of first-line oral pharmaceuticals so as to justify usage of topical agents and/or topical compounds such as the [REDACTED] gel, which are largely experimental, per the Chronic Pain Medical Treatment Guidelines. Therefore, the request is not certified.

**120 ML OF GABAPENTIN 10% 0.075% SPRAY WITH FOUR REFILLS:** Upheld

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

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

**Decision rationale:** As noted in the MTUS Chronic Pain Medical Treatment Guidelines, Gabapentin is specifically not recommended for topical compound formulation purposes. In this case, the attending provider has not provided any applicant-specific rationale, narrative, or commentary so as to try and offset the unfavorable MTUS recommendation. Therefore, the request is not certified.

**120 GMS OF CAPSAICIN 0.05%, CAMPHOR 2%, MENTHOL 1%, LIDOCAINE 2%, GABAPENTIN 10% GEL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines do not endorse the use of Gabapentin for topical compound formulation purposes. The unfavorable recommendation of Gabapentin, an ingredient in the requested gel, results in the entire gel not being recommended, as per the Chronic Pain Medical Treatment Guidelines' statement that if one drug or drug class in a compounded medication is not recommended, the entire compound is not recommended. Accordingly, the request is not certified.