

<b>Case Number:</b>	CM13-0052765		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	01/01/2008
<b>Decision Date:</b>	06/03/2014	<b>UR Denial Date:</b>	10/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2013

### 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 Family Practice, and is licensed to practice in California, Tennessee, and Virginia. 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 53-year-old injured on January 1, 2008 due to undisclosed mechanism of injury. Current diagnoses included lumbar spine herniated nucleus pulposus with chronic L4-5 radiculopathy, thoracic spine musculoligamentous sprain/strain, severe anxiety, depression, insomnia, and acid reflux. The injured complained of chronic pain in the lumbosacral spine with associated depression, severe anxiety, and sleeplessness. Routine psychotherapy for in depth psychiatric issues is noted. Medications included Colace, Prilosec, and Medrox Patches.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **RETROSPECTIVE 1 PRESCRIPTION TOPICAL COMPOUND 240GM:: 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 Section, Page(s): 111.

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that

these types of medications have been trialed and/or failed. Further, the Chronic Pain Medical Treatment Guidelines, Food and Drug Administration (FDA), and Official Disability Guidelines (ODG) require that all components of a compounded topical medication be approved for transdermal use. The components of this compound were not provided to establish the United States Federal Drug Administration approval status. The request for one retrospective prescription for topical compound 240 gm is not medically necessary or appropriate.