

<b>Case Number:</b>	CM14-0007459		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	11/02/2003
<b>Decision Date:</b>	06/23/2014	<b>UR Denial Date:</b>	12/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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 Physical Medicine and Rehabilitation, and is licensed to practice in Texas. 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 37-year-old male who sustained work related injuries on November 2, 2003. Mechanism of injury was reported to be the result of a fall followed by heavy lifting which resulted in onset of low back and right lower extremity pain. The injured worker subsequently was treated with interventional procedures including epidural steroid injection on July 27, 2004 with subsequent injection in January of 2007 he further was noted to have undergone lumbar facet blocks. The injured worker had diagnosis of low back pain, lumbosacral neuritis, and displacement of intervertebral disc. Current medications included baclofen 10mg hydrocodone 10 650mg Lunesta 2mg and Topiramate 50mg the most recent physical examination dated November 13, 2013 noted that the injured worker continued to have low back pain and requested to undergo lumbar rhizotomy. There was some superficial hypersensitivity over the low back to light touch as moderate pain with lumbar flexion extending more right than left. There was palpable spasm of the lumbar facet joints. Straight leg raise was positive causing low back pain and some achiness. The injured worker was prescribed cyclogaba cream 10%/10%. Utilization review determination dated December 18, 2013 non-certified the request for cyclogaba cream 10%/10% number one two.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CYCLOGABA CREAM 10% /10% #1 TUBE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113.

**Decision rationale:** The California Medical Treatment Utilization Schedule, Official Disability Guidelines and US FDA do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: cyclobenzaprine 10%, and gabapentin 10% which have not been approved by the FDA for transdermal use. The request for Cyclogaba cream 10% /10%, one tube, is not medically necessary or appropriate.