

Case Number:	CM14-0008469		
Date Assigned:	02/12/2014	Date of Injury:	03/23/2012
Decision Date:	06/24/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/22/2014

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 Orthopedic Surgery 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 42 year old female injured on 03/23/12 due to undisclosed mechanism of injury. Current diagnoses included low back pain, lumbar disc displacement, and lumbar radiculopathy. Clinical note dated 01/16/14 indicated the injured worker presented with low back pain radiating into the right flank and buttock with associated numbness, paresthesia, and weakness. The injured worker was status post lumbar epidural steroid injection on 09/23/13 with reported pain reduction greater than 50%; however, the injured worker reported the pain was returning. Physical examination revealed paralumbar spasm, 2+ tenderness to palpation on the right, atrophy in quadriceps, decreased range of motion in lumbar spine, straight leg raise positive on the right, lower extremity deep tendon reflexes absent at knees, sensation decreased to right flank, and motor strength of lower extremities measured 5/5 in all muscle groups bilaterally. Prior treatments included lumbar epidural steroid injection, ice/heat, non steroidal anti-inflammatory medications (NSAIDs), and medication management. The injured worker was prescribed naproxen 550mg, Cyclobenzaprine 7.5mg, Ondansetron 8mg, omeprazole 20mg, tramadol 150mg, and Terocin patch. The initial request for Cooleeze compound medication #120 gabapentin 10% in Capsaicin solution #120 (no body part specified) was initially non-certified on 12/27/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

MED THE REQUEST FOR COOLEEZE COMPOUND MED #120: 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 CHRONIC PAIN MEDICAL TREATMENT GUIDELINES 9792.20, TOPICAL ANALGESICS Page(s): 111.

Decision rationale: As noted on page 111 of 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, California Medical Treatment Utilization Schedule (CAMTUS), Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore Cooleeze Compound Med #120 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

GABAPENTIN 10% IN CAPSAICIN SOLUTION #120 (NO BODY PART SPECIFIED):
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 CHRONIC PAIN MEDICAL TREATMENT GUIDELINES 9792.20, TOPICAL ANALGESICS Page(s): 111.

Decision rationale: As noted on page 111 of 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, California Medical Treatment Utilization Schedule (CAMTUS), Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Gabapentin has not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore Gabapentin 10% In Capsaicin Solution #120b cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.