

<b>Case Number:</b>	CM14-0105889		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	10/22/2010
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2014

### 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 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 42-year-old male who reported an injury on 10/22/2010. The mechanism of injury involved heavy lifting. The current diagnosis is right biceps strain and tears. The injured worker was evaluated on 05/13/2014. Previous conservative treatment includes postoperative physical therapy. It is noted that the injured worker underwent a right biceps repair on an unknown date. The injured worker presented with complaints of persistent pain in the right upper arm with activity limitation. The injured worker was not currently utilizing any medication. Physical examination revealed well healed surgical scars, decreased motor strength in the right biceps, normal pronation and supination, normal wrist dorsiflexion and palmar flexion, normal ulnar and radial deviation, 2+ deep tendon reflexes, negative orthopedic testing, intact sensation, and normal grip strength. Treatment recommendations at that time included physical therapy for the right upper extremity, an MRI, and prescription cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Compound Transdermal Cream: Cyclobenzaprine Powder 3gm, DOS: 5/13/14:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole." Cyclobenzaprine is not recommended as there is no evidence for the use of a muscle relaxant as a topical product. Therefore, the request is not medically necessary.

**Compound Transdermal Cream: Gabapentin Powder 3gm, Date of Service 5/13/14:**  
Upheld

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

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

**Decision rationale:** California MTUS Guidelines state "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole." Gabapentin is not recommended as there is no peer reviewed literature to support its use as a topical product. As such, the request is not medically necessary.