

<b>Case Number:</b>	CM14-0107482		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	03/26/2013
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	06/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2014

### 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 Anesthesiology, has a subspecialty in Pain 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 injured worker is a 59 year old male injured on 03/26/13 due to undisclosed mechanism of injury. The injuries sustained were not provided in the documentation. Documentation indicated the injured worker underwent right L4-5 and L5-S1 transforaminal epidural steroid injection on 06/23/14. Diagnoses included lumbar discopathy with radiculopathy, right knee medial meniscus tear with chondromalacia patella and sprain of the anterior cruciate ligament, left knee medial meniscus tear with chondromalacia patella, and electrodiagnostic studies evident of chronic left S1 and right L5-S1 poly radiculopathy. Clinical note dated 02/03/14 indicated the injured worker presented complaining of persistent low back pain aggravated by multiple factors. The injured worker also complained of bilateral knee pain. Physical examination of the lumbar spine revealed tenderness from mid to distal lumbar segments, pain with terminal motion, seated nerve root test positive, dysesthesia at L5 and S1 dermatomes on the right greater than left. Examination of bilateral knees revealed tenderness at bilateral medial joint line and anteriorly, positive McMurray sign, positive patellar compression test, and pain with terminal flexion with crepitus. Treatment plan included referral for physical therapy. Additional clinical documentation indicated the injured worker underwent consultation for transforaminal epidural steroid injection. Complete list of medications was not provided for review. The initial request was non-certified on 06/18/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 10% / Capsaicin 0.025% CRM #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 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. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be 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 Flurbiprofen 10% / Capsaicin 0.025% CRM #120 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

**Gab 10% / Lid 2% / Aloe 5% / Cap .025% / Men 10% / Cam 5% GEL #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 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. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains gabapentin which 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 Gab 10% / Lid 2% / Aloe 5% / Cap .025% / Men 10% / Cam 5% GEL #120 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.