

<b>Case Number:</b>	CM14-0015302		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	02/26/2005
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	02/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2014

### 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 Anesthesiologist, has a subspecialty in Pain Medicine, 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 49 year old male who is reported to have sustained work related injuries to his low back on 02/26/05. It is reported he injured his low back while installing a transmission into a vehicle. Records indicate on 09/06/05, the injured worker underwent a right L4 hemilaminotomy, L4-5 microdiscectomy with nerve root exploration, left L5 hemilaminotomy, and L5-S1 microdiscectomy. The records indicate there was a break in treatment. The injured worker presented on 01/07/14 for persistent symptoms of lower back pain with radiation to the posterior aspect of the right lower extremity. On physical examination, it was noted there was tenderness and decreased range of motion of the lumbar spine. A positive straight leg raise with radicular signs. Deep tendon reflexes were reported to be normal. There was a questionable decrease in sensation in the right anterior thigh. An electrodiagnostic (EMG/NCV) study was performed on 01/22/14 and showed abnormal electromyography (EMG) findings suggestive of a bilateral chronic active L5-S1 radiculopathy. The record includes a utilization review determination dated 02/06/14 in which requests for Cyclobenzaprine 12mg, Gabapentin powder 12mg, Flurbiprofen powder 30mg, and Tramadol powder 30mg were non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FLURBIPROFEN POWDER 30 MG (DATE OF SERVICE 01/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, 111-113, and 105..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Compounded Medications

**Decision rationale:** The request for Flurbiprofen powder 30mg is not supported as medically necessary. The California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US Food and Drug Administration 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: Flurbiprofen which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.

**GABAPENTIN POWDER 12 MG (DATE OF SERVICE 01/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, 111-113, and 105..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Compounded Medications

**Decision rationale:** The request for Gabapentin powder 12mg is not supported as medically necessary. The California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US Food and Drug Administration 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: Gabapentin which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.

**CYCLOBENZAPRINE 12 MG (DATE OF SERVICE 01/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, 111-113, and 105..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Compounded Medications

**Decision rationale:** The request for Cyclobenzaprine 12mg is not supported as medically necessary. The California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US Food and Drug Administration 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 which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.

**TRAMADOL POWDER 30 MG (DATE OF SERVICE 01/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, 111-113, and 105..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, 112-113.

**Decision rationale:** The request for Tramadol powder 30mg is not supported as medically necessary. The California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US Food and Drug Administration 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: Tramadol which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.