

<b>Case Number:</b>	CM14-0039613		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	09/30/2013
<b>Decision Date:</b>	08/19/2014	<b>UR Denial Date:</b>	03/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/04/2014

### 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 34 year old male who had a work related injury on 09/30/13. The injured worker was standing on a ladder 14-15 feet high when the ladder slipped back. He fell forward along with the ladder onto the ground and impacted the floor with his chest and ribs. The injured worker felt immediate pain in his left wrist, elbow, chest, and low back. He was taken to the local hospital. X-rays of chest and low back revealed broken L1 vertebra and possible rib fractures. He was admitted for two days. The records demonstrated treatment consisted of physical therapy, pain medication, compounded medications, and lumbar support. The most recent progress note dated 02/05/14 stated the injured worker complained of low back ribcage pain. On physical examination there was 3+ spasm and tenderness to the bilateral thoracic paraspinal muscles from T3 to T9 and bilateral intercostal muscles between ribs six and ten. It was noted upon lumbar examination the injured worker was wearing a thoracolumbosacral orthosis (TLSO) brace. There was 3+ spasm tenderness to the bilateral lumbar paraspinal muscles from L1 to L5. Lumbar range of motion was captured digitally by acumar, Kim test was positive bilaterally. Straight leg raise test was positive on the left. Yeoman was positive bilaterally. Braggard was positive on the left. Left hamstring reflex was decreased. Left achilles reflex was decreased. S1 dermatome was decreased on left to light touch. There was 1+ spasm and tenderness to the left tensor fascia lata muscle and left gluteus medius muscle. Faber test was positive on the left. Anvil test was positive on the left. Diagnoses closed fracture of lumbar vertebra and lumbar disc displacement myelopathy; including thoracic disc displacement without myelopathy, sciatica, and left hip sprain/strain. Prior utilization review on 03/03/14 was not medically recommended for the compounded medication and functional capacity evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Request for 1 prescription of Lidocaine/ Gabapentin/ Tramadol compound # 180 mg. with 2 refills:** 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, compound drugs.

**Decision rationale:** The request for one prescription of Lidocaine/ Gabapentin/ Tramadol compound # 180 mg. with two refills is not medically necessary. The current evidence based guidelines do not support the request. California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US Food and Drug Administration (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: Gabapentin and Tramadol which have 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 is not recommended. Therefore, the request is not medically necessary.

**Request for 1 prescription of Flurbiprofen/ Cyclobenzaprine/ Baclofen/ Lidocaine compound # 180 mg. with 2 refills:** 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 based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter, Compound drugs.

**Decision rationale:** The request for for one prescription of Flurbiprofen/ Cyclobenzaprine/ Baclofen/ Lidocaine compound # 180 mg. with two refills refills is not medically necessary. The current evidence based guidelines do not support the request. California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US Food and Drug Administration (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/ Baclofen which have 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 is not recommended. Therefore, the request is not medically necessary.

**Request for 1 functional capacity evaluation:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Functional Capacity Evaluation (FCE).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for work, Functional capacity evaluation (FCE).

**Decision rationale:** The request for one functional capacity evaluation is medically necessary. The current evidence based guidelines support the request. The injured worker has been out of work for an extended period of time, to see if he is able to return to that line of work would be beneficial. Therefore, medical necessity has been established.