

<b>Case Number:</b>	CM14-0046957		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	03/10/2009
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	03/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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 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 64 year old male who reported an injury on 03/10/2009. The mechanism of injury was not stated. Current diagnoses include cervical spine pain, radiculitis in the upper extremity, lumbar spine sprain, lumbar radiculopathy, anxiety, mood disorder, and sleep disorder. The current request is for a compounded medication dispensed on 02/21/2011 and 10/21/2011. However, there were no physician progress reports submitted on the requesting dates. The injured worker was evaluated on 09/18/2013 with complaints of 7/10 neck and lower back pain. Physical examination revealed tenderness to palpation at the suboccipital region, decreased range of motion of the cervical spine, diminished sensation in the bilateral upper extremities, 4/5 motor strength in the bilateral upper extremities, painful range of motion of the lumbar spine, tenderness with spasm in the lumbar paraspinal muscles, decreased lumbar range of motion, positive straight leg raising bilaterally, decreased motor strength, and decreased sensation. Treatment recommendations at that time included continuation of the current medication regimen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Request with date of service of 2/21/2011 for Capsaicin/Menthol/Camphor/Diclofenac: 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:** The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. The only FDA approved topical NSAID is Diclofenac, which is indicated for the relief of osteoarthritis pain. There was no physician progress report submitted on the requesting date. There is no strength, frequency or quantity listed in the current request. Based on the clinical information received, the request is not medically necessary and appropriate.

**Retrospective Request with date of service of 10/21/2011 for: Caps/Menth/Camph/Diclo, Amitrip/Dextro/Tram:** 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:** The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. The only FDA approved topical NSAID is Diclofenac, which is indicated for the relief of osteoarthritis pain. There was no physician progress report submitted on the requesting date. There is no strength, frequency or quantity listed in the current request. Based on the clinical information received, the request is not medically necessary and appropriate.