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| <b>Case Number:</b>   | CM14-0050027 |                              |            |
| <b>Date Assigned:</b> | 07/07/2014   | <b>Date of Injury:</b>       | 09/23/2008 |
| <b>Decision Date:</b> | 08/26/2014   | <b>UR Denial Date:</b>       | 04/01/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/17/2014 |

### 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 37 year-old female who was reportedly injured on 9/23/2008. The mechanism of injury is noted as a lifting injury. The most recent progress note, dated 5/2/2014, indicates that there are ongoing complaints of chronic neck pain, left shoulder pain, left wrist pain, low back pain, bilateral knee pain, and left ankle pain. The physical examination demonstrated positive tenderness to palpation throughout the cervical spine and lumbar spine. Examination of the bilateral shoulders/elbows/wrists was unremarkable. Examination of the lumbar spine revealed tenderness to palpation throughout the entire lumbar spine. Range of motion could not be assessed secondary to pain. Bilateral knees were tender to palpation at the patellofemoral joint and patella pressure did cause discomfort. Examination of the bilateral ankles/feet was unremarkable. Diagnostic imaging studies of the thoracic spine were unremarkable and lumbar spine reveal posterior instrumentation at L5-S1 with anterior interbody graft in good position. X-Ray of the pelvis reveals bullet over the right femur with no evidence of fracture. Previous treatment includes spinal surgery, physical therapy, and medications. Medications denied on 04/01/2014 were: Compounded Flurbiprofen 20% / Lidocaine 5% / Amitriptyline 5%, 30 grams Ultraflex-G 30 gram (Gabapentin 10% / Cyclobenzaprine 6% / Tramadol 10%) Compounded Flurbiprofen 20% Tramadol 20%/Cyclobenzaprine 4% cream Compounded Gabapentin 10% / Amitriptyline 10% / Dextromethorphan 10% cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FlurLido - Compounded Flurbiprofen 20% / Lidocaine 5% / Amitriptyline 5%, 30 grams:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 111-112.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines support topical non-steroidal anti-inflammatory drugs for the short-term treatment of acute pain for short-term use for individuals unable to tolerate oral administration, or for whom oral administration is contraindicated. The record provides no documentation that the claimant has or is taking an oral anti-inflammatory. When noting the claimant's diagnosis of left knee pain and no documentation of osteoarthritis, intolerance or contraindication to first-line therapies, there is no clinical indication for the use of this medication for the diagnoses noted. Therefore, this request is deemed not medically necessary.

**Ultraflex-G 30 gram (Gabapentin 10% / Cyclobenzaprine 6% / Tramadol 10):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 111-113.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines state that topical analgesics are largely experimental and that any compounded product that contains at least one drug (or drug class) that is not recommended is then not recommended. The guidelines note there is little evidence to support the use of this compounded cream for pain. Furthermore, there is no documentation of any conservative treatment, physical therapy or first-line medications. As such, this request is not considered medically necessary.

**Compounded Flurbiprofen 20% Tramadol 20%/Cyclobenzaprine 4% cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009); Page(s): 111-113.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines state that topical analgesics are largely experimental and that any compound product that contains at least one drug (or drug class) that is not recommended is then not recommended. The guidelines note there is little evidence to support the use of this compounding cream for pain. Furthermore, there

is no documentation of any conservative treatment, physical therapy or first-line medications. As such, this request is not considered medically necessary.

**Compounded Gabapentin 10% / Amitriptyline 10% / Dextromethorphan 10%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009); Page(s): 111-113.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines state that topical analgesics are largely experimental and that any compound product that contains at least one drug (or drug class) that is not recommended is then not recommended. The guidelines note there is little evidence to support the use of this compounding cream for pain. Furthermore, there is no documentation of any conservative treatment, physical therapy or first-line medications. As such, this request is not considered medically necessary.