

<b>Case Number:</b>	CM14-0081254		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	08/14/2009
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	05/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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 & Rehabilitation and Pain Medicine and is licensed to practice in California and Washington. 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 55-year-old male who reported an injury on 08/14/2009. The mechanism of injury was not provided. On 04/22/2014, the injured worker presented with low back pain, pain in the bilateral knees, and complaints of sleep loss. Upon examination there was tenderness to palpation of the lumbar paraspinal muscles, muscle spasm of the lumbar paravertebral muscles, and a positive Kemp's and straight leg raise bilaterally. There was decreased range of motion in the right knee and tenderness to over the anterior knee, lateral knee, and medial knee, with a positive McMurray's. Examination of the left knee revealed decreased painful range of motion, tenderness to palpation of the anterior of the knee, lateral knee, and medial knee, and a positive McMurray's. The diagnoses were lumbar disc protrusion, lumbar myospasm, lumbar radiculopathy, lumbar sprain, right knee internal derangement, right knee sprain/strain, left knee internal derangement, left knee sprain/strain, and loss of sleep. A current medication list was no provided. The provider recommended Flurbiprofen 20%/tramadol 20%, in Mediderm base 30 g and gabapentin 10%/Dextromethorphan 10%/amitriptyline 10% in Mediderm base, 240 g, the provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 20% / Tramadol 20% in Mediderm Base 30 grams:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request for Flurbiprofen 20% / Tramadol 20% in Mediderm Base 30 grams is not medically necessary. California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Many agents are compounded as monotherapy are in combination for pain control including NSAIDs, opioids, Capsaicin, local anesthetics, antidepressants, and NSAIDs. There is little to no research to support the use of many of these agents or documentation that the injured worker failed a trial of antidepressant or anticonvulsant. Additionally, the provider's request does not indicate the site that the cream is indicated for or the frequency in the request as submitted. As such, the request is not medically necessary.

**Gabapentin 10% / Dextromethorphan 10% / Amitriptyline 10% in Mediderm base 240 grams:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request for Gabapentin 10% / Dextromethorphan 10% / Amitriptyline 10% in Mediderm base 240 grams is not medically necessary. California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Many agents are compounded as monotherapy are in combination for pain control including NSAIDs, opioids, Capsaicin, local anesthetics, antidepressants, and NSAIDs. There is little to no research to support the use of many of these agents or documentation that the injured worker failed a trial of antidepressant or anticonvulsant. Additionally, the provider's request does not indicate the site that the cream is indicated for or the frequency in the request as submitted. As such, the request is not medically necessary.