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| <b>Case Number:</b>   | CM14-0084173 |                              |            |
| <b>Date Assigned:</b> | 07/21/2014   | <b>Date of Injury:</b>       | 08/09/1999 |
| <b>Decision Date:</b> | 10/01/2014   | <b>UR Denial Date:</b>       | 05/06/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/05/2014 |

### 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 Internal 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 56 year old male who sustained an injury on 08/09/99. No specific mechanism of injury was noted. The injured worker was followed for complaints of chronic low back pain radiating to the lower extremities right side worse than left. The injured worker was also followed for complaints of neck pain. Prior treatment included multiple epidural steroid injections which provided up to 50% relief for two months. The injured worker reported no improvement with anti-inflammatories. As of 05/15/14 the injured worker continued to report a dysthymic mood secondary to chronic pain. This record was completed by a psychologist. No other updated clinical records for pain management medications were noted. The requested compounded topical medications including Gabapentin Lidocaine Menthol and Capsaicin and separate Flurbiprofen and Capsaicin patch were denied by utilization review on 05/18/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**GABAPENTIN 10%/LIDOCAINE 2% IN W/ ALOE VERA 0.5%/CAPSAOCON (NATURAL) 0.025%/MENTHOL 10%/CAMPBOR 5% GEL QTY 120:** 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): 111-113.

**Decision rationale:** In regards to the use of a topical analgesic that contains Gabapentin, Lidocaine, Capsaicin, Menthol, and Camphor; this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Gabapentin which is not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound cannot be supported as medically necessary.

**FLURBIPROFEN/CAPSAICIN (PATCH) 10% 0.025% CRM QTY 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 28-29.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** In regards to the use of a topical analgesic patch that contains Flurbiprofen and Capsaicin; this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Flurbiprofen which is not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound cannot be supported as medically necessary.