

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0093072 |                              |            |
| <b>Date Assigned:</b> | 07/25/2014   | <b>Date of Injury:</b>       | 06/22/2011 |
| <b>Decision Date:</b> | 09/30/2014   | <b>UR Denial Date:</b>       | 06/06/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/19/2014 |

### 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, Colorado, Kentucky, and North Carolina. 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 patient is a 63-year-old injured on 06/22/11 as a result of lifting clients while transferring them to and from their beds and wheelchairs. The injured patient initially complained of shoulder, arm, wrist, hand, and finger pain. QME on 04/01/14 indicated MRI of the right shoulder in 2012 revealed spur formation of the acromioclavicular joint from degenerative changes, intrasubstance tear or tendinosis, vertical tear of superior glenoid labrum extending to the undersurface of the structure. MRI of the lumbar spine revealed disc protrusions at L4-5 and L5-S1. The injured patient received ongoing treatment for sleep disorder, depression/anxiety, gastritis, and aggravation of hypertension. QME determined hypertension, diabetes mellitus, and GERD were non-industrial preexisting disorders. Medications included atenolol, Accupril, metformin, Lipitor, omeprazole, and Mobic. The initial request for retrospective review of keto/cyclo/versapro 10/2% 120mL (compounds) date of service 11/04/13 was non-certified on 06/06/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Keto/Cyclo/Versapro 10/2% 120 ml (compounds), provided on November 4, 2013:** 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 rationale:** According to the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains ketoprofen and cyclobenzaprine which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, the request for Keto/Cyclo/Versapro 10/2% 120 ml (compounds), provided on November 4, 2013, is not medically necessary or appropriate.