

<b>Case Number:</b>	CM15-0109365		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	04/08/2011
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: California, North Carolina  
Certification(s)/Specialty: Family Practice

### 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 54-year-old male, who sustained an industrial injury on April 8, 2011, incurring low back injuries. He was diagnosed with lumbar sprain, lumbar disc displacement, lumbar facet syndrome and lumbar radiculopathy. Treatment included anti-inflammatory drugs, pain medications, muscle relaxants, proton pump inhibitor, anti-anxiety medications and work restrictions. Currently, the injured worker complained of low dull aching back pain radiating with numbness and tingling to the lower extremities aggravated by bending, lifting and activities. He complained of loss of sleep due to the pain, and anxiety and depression. The treatment plan that was requested for authorization included a prescription for a compound cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10% 180G: 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:** The CA MTUS states that topical agents are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain. Any compounded product that contains at least one drug that is not recommended is not recommended. In this case, there is no indication that first-line oral agents have failed or are not tolerated, necessitating the use of a topical agent. The product contains Gabapentin, which is specifically not recommended due to no peer reviewed literature to support its use. The request is deemed not medically necessary or appropriate.