

<b>Case Number:</b>	CM15-0218549		
<b>Date Assigned:</b>	11/10/2015	<b>Date of Injury:</b>	12/16/2011
<b>Decision Date:</b>	12/22/2015	<b>UR Denial Date:</b>	10/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 53 year old male, who sustained an industrial injury on 12-16-2011. He has reported injury to the neck and low back. The diagnoses have included cervical spine herniated nucleus pulposus; and lumbar spine herniated nucleus pulposus. Treatment to date has included medications, diagnostics, rest, heat, ice, physical therapy, and home exercise program. Medications have included topical compounded creams. A progress report from the treating physician, dated 03-04-2015, documented an evaluation with the injured worker. The injured worker reported low back pain, rated at 7 out of 10 in intensity. Objective findings included positive tenderness to palpation and spasm of the lumbar spine. The treatment plan has included the request for retrospective Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10%, 180g (date of service: 03-30-15); and retrospective Cyclobenzaprine 2%, Flurbiprofen 25%, 180g (date of service: 03-30-15). The original utilization review, dated 10-28-2015, non-certified the request for retrospective Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10%, 180g (date of service: 03-30-15); and retrospective Cyclobenzaprine 2%, Flurbiprofen 25%, 180g (date of service: 03-30-15).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10%, 180g (DOS: 3/30/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Amitriptyline, Antiepilepsy drugs (AEDs), Topical Analgesics.

**Decision rationale:** The MTUS Guidelines recommend the use of topical analgesics as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The MTUS Guidelines do not recommend the use of topical gabapentin, as there is no peer-reviewed literature to support use. Amitriptyline is a tricyclic antidepressant that shares some properties of muscle relaxants. The MTUS Guidelines and ODG do not address the use of amitriptyline or other antidepressants as topical agents for pain, however, the MTUS Guidelines specifically reports that there is no evidence to support the use of topical formulations of muscle relaxants. Dextromethorphan is FDA approved an antitussive. Uses for chronic pain are investigational and experimental. As at least one of the medications in the requested compounded medication is not recommended by the guidelines, the request for retrospective Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10%, 180g (DOS: 3/30/15) is not medically necessary.

**Retrospective Cyclobenzaprine 2%, Flurbiprofen 25%, 180g (DOS: 3/30/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), Cyclobenzaprine (Flexeril), Topical Analgesics.

**Decision rationale:** The MTUS Guidelines recommend the use of topical analgesics as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The MTUS Guidelines state that there is no evidence for use of muscle relaxants, such as cyclobenzaprine, as a topical product. Topical NSAIDs, have been shown to be superior to placebo for 4-12 weeks for osteoarthritis of the knee. Topical flurbiprofen is not an FDA approved formulation. As at least one of the medications in the requested compounded medication is not recommended by the guidelines, the request for retrospective Cyclobenzaprine 2%, Flurbiprofen 25%, 180g (DOS: 3/30/15) is not medically necessary.