

<b>Case Number:</b>	CM15-0116367		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	08/13/2013
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2015

### 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 73 year old male who sustained an industrial injury on 08/13/2013. There was no mechanism of injury documented. The injured worker was diagnosed with cervical herniated nucleus pulposus, cervical radiculopathy, bilateral shoulder internal derangement, bilateral wrist sprain/strain and tenosynovitis, lumbar herniated nucleus pulposus with radiculopathy, bilateral internal knee derangement, bilateral ankle sprain/strain, and anxiety, stress and sleep disorder. The injured worker has a medical history of diabetes mellitus and hypertension. There were no documented surgical interventions. Diagnostic testing included lumbar, cervical spine, bilateral shoulders and bilateral knee magnetic resonance imaging (MRI) in November and December 2014. Except for medications, there was no documentation of therapies trialed. According to the primary treating physician's progress report on February 24, 2015, the injured worker continues to experience neck, bilateral shoulders, bilateral wrists, lower back, bilateral knee and ankle pain associated with spasm. The injured worker reports the neck pain involves numbness and tingling of the bilateral upper extremities and his low back pain involves numbness and tingling of the bilateral lower extremities. The injured worker rates his pain level at 4-5/10. Examination of the cervical spine reveals decreased active range of motion with tenderness to palpation at the suboccipital area over the trapezius and scalene muscles. The bilateral shoulders noted tenderness to palpation at the delto-pectoral groove and at the insertion of the supraspinatus muscle with active decreased range of motion on flexion, extension, internal and extension rotation. The bilateral wrists demonstrated tenderness to palpation over the carpal bones, thenar and hypothenar eminence bilaterally with full active range of motion. Sensation to pinprick and light touch was slightly diminished over C5 through T1 dermatome distribution in the bilateral upper extremities with motor strength at 4/5 in the

upper extremity muscle groups. Deep tendon reflexes and vascular pulses were within normal limits. The lumbar spine examination demonstrated tenderness at the paraspinal muscles and over the lumbosacral junction with decreased range of motion and bilateral positive straight leg raise. The injured worker was able to heel and toe walk with pain and toe touch with fingers about three inches from the ground. The bilateral knees were tender over the medial and lateral joint line without ligament instability and 10 degrees decrease in range of motion on flexion. Bilateral ankles noted tenderness to palpation over the medial and lateral malleolus with full range of motion. Sensory was slightly decreased at the L4, L5 and S1 dermatomes bilaterally and motor strength was 4/5 in the bilateral lower extremities. Bilateral lower extremity deep tendon reflexes and vascular were intact. Current medications are listed as Tabradol, Deprizine, Dicopanol, Fanatrex, Synapryn and Gabapentin. Treatment plan consists of physical therapy and acupuncture therapy and the current request for topical analgesics of Capsaicin .025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2% and Cyclobenzaprine 2%, Gabapentin 15%, Amitriptyline 10%.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Cyclobenzaprine 2%, Gabapentin 15%, Amitriptyline 10% 180gm #1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

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

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no evidence for use of any muscle relaxant as a topical product. Cyclobenzaprine 2%, Gabapentin 15%, Amitriptyline 10% 180gm #1 is not medically necessary.

**Capsaicin .025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2% 180gm #1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics.

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

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Capsaicin .025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2% 180gm #1 is not medically necessary.