

<b>Case Number:</b>	CM14-0143744		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	05/18/2006
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	08/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2014

### 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 Texas. 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 72 year old male who reported an injury on 5/18/06 to his low back. No information was submitted regarding the initial injury. The clinical note dated 07/01/14 indicates the injured worker complaining of lumbosacral pain with radiating pain into both lower extremities, right greater than left. The note indicates the injured worker utilizing Motrin as well as topical analgesics for pain relief. The utilization review dated 06/05/14 resulted in denials for a functional restoration program as well as topical analgesics and 1 consultation per month as insufficient information had been submitted regarding the injured worker's medical need for a functional restoration program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 20%, tramadol 20%, 30 grams #240: 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:** 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. There is no indication in the documentation that these types of medications have been trialed and/or 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. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore this compound does not meet established and accepted medical guidelines.

**Amitriptyline 10%,Gabapentin 10% Dextromethorphan 10% 30 grams #240: 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:** 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. There is no indication in the documentation that these types of medications have been trialed and/or 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. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore this compound does not meet established and accepted medical guidelines.

**Functional restoration program: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-1.

**Decision rationale:** A functional restoration program (FRP) is indicated for injured workers who have demonstrated significant functional deficits likely to benefit from a multidisciplinary approach and the injured worker has completed all conservative treatments as well as a functional capacity evaluation. No information was submitted regarding the injured worker's completion of any conservative treatments addressing the ongoing complaints. Additionally, no functional capacity evaluation was submitted confirming the injured worker's functional deficits. Therefore, this request is not indicated as medically necessary.

**Consultation one per month: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM for Independent Medical Examinations and Consultations regarding Referrals, Chapter 7

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) IME and Consultations, Page 503

**Decision rationale:** The documentation does indicate the injured worker having ongoing complaints of low back pain. However, no information was submitted regarding the injured worker's ongoing need on a monthly basis for aid with diagnosis, prognosis, and a potential return to work. Therefore, this request is not indicated as medically necessary.