

Case Number:	CM14-0016991		
Date Assigned:	03/07/2014	Date of Injury:	02/06/2007
Decision Date:	06/30/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/10/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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 patient is a 57 year old female with date of injury 2/6/07. The primary treating physician report dated 1/17/14 indicates that the patient presents with pain affecting the lumbar spine, right shoulder, right wrist and right knee. The current diagnoses are: 1.Carpal tunnel syndrome 2.Rotator cuff syndrome 3.Lumbar disc syndrome 4.Internal derangement of knee The utilization review report dated 1/27/14 denied the request for Amitriptyline, Dextromethorphan, Tramadol and Ultraderm. The pain management reports reviewed by utilization review were dated 12/7/11 and 2/15/12. The rationale for denial was based on lack of medical necessity and MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMITRIPTYLINE 4%, DOS: 02/15/2012: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Compound Medications, Mtus And Pain Chapter, Odg.

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

Decision rationale: The patient presents with chronic pain affecting the lumbar spine, right shoulder, right wrist and right knee. The current request is for Amitriptyline 4%, DOS 2/15/12. I have reviewed the 270 pages that were provided for review and there is no report provided that requests the 4 topical analgesics that have been presented for Independent Medical Review. The utilization review report dated 1/27/14 states that the pain management physician report dated 2/15/12 states, "The patient recently had MRIs of the shoulder, knee and back. The present medication regimen was ineffective. The patient's medications were refilled; MS Contin, Tizanadine, Diclofenac 30% cream and Capsaicin T3 cream. Another cream was added: Amitriptyline 4%, Dextromethorphan 10%, Tramadol 20%, Ultraderm. A urine drug screen was obtained." The current request is not supported as there is no report available for review that states what the current prescription is for, the quantity of medication prescribed or the dosage amount of the medication. Furthermore, the MTUS guidelines regarding topical analgesics and compounded topical agents state, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." There is no medical information to indicate exactly what is being prescribed and there is no rationale as to why these 4 topical medications are medically necessary. This request is not medically necessary.

DEXTROMETHORPHAN 10%, DOS: 02/15/2012: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Compound Medications, MTUS And Pain Chapter, ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN SECTION Page(s): 111.

Decision rationale: The patient presents with chronic pain affecting the lumbar spine, right shoulder, right wrist and right knee. The current request is for Dextromethorphan 10%, DOS 2/15/12. I have reviewed the 270 pages that were provided for review and there is no report provided that requests the 4 topical analgesics that have been presented for Independent Medical Review. The utilization review report dated 1/27/14 states that the pain management physician report dated 2/15/12 states, "The patient recently had MRIs of the shoulder, knee and back. The present medication regimen was ineffective. The patient's medications were refilled; MS Contin, Tizanadine, Diclofenac 30% cream and Capsaicin T3 cream. Another cream was added: Amitriptyline 4%, Dextromethorphan 10%, Tramadol 20%, Ultraderm. A urine drug screen was obtained." The current request is not supported as there is no report available for review that states what the current prescription is for, the quantity of medication prescribed or the dosage amount of the medication. Dextromethorphan is a cough suppressant and is not utilized for the treatment of musculoskeletal pain. Furthermore, the MTUS guidelines regarding topical analgesics and compounded topical agents state, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." There is no medical information to indicate exactly what is being prescribed and there is no rationale as to why these 4 topical medications are medically necessary. This request is not medically necessary.

TRAMADOL 20%, DOS: 02/15/2012: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Compound Medications, MTUS AND ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN SECTION Page(s): 111.

Decision rationale: The patient presents with chronic pain affecting the lumbar spine, right shoulder, right wrist and right knee. The current request is for Tramadol 20%, DOS 2/15/12. I have reviewed the 270 pages that were provided for review and there is no report provided that requests the 4 topical analgesics that have been presented for Independent Medical Review. The utilization review report dated 1/27/14 states that the pain management physician report dated 2/15/12 states, "The patient recently had MRIs of the shoulder, knee and back. The present medication regimen was ineffective. The patient's medications were refilled; MS Contin, Tizanadine, Diclofenac 30% cream and Capsaicin T3 cream. Another cream was added: Amitriptyline 4%, Dextromethorphan 10%, Tramadol 20%, Ultraderm. A urine drug screen was obtained." The current request is not supported as there is no report available for review that states what the current prescription is for, the quantity of medication prescribed or the dosage amount of the medication. Furthermore, the MTUS guidelines regarding topical analgesics and compounded topical agents state, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." There is no medical information to indicate exactly what is being prescribed and there is no rationale as to why these 4 topical medications are medically necessary. MTUS also does not support Tramadol for topical cream. The request is not medically necessary.

ULTRADERM, DOS: 02/15/2012: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Compound Medications, MTUS And Pain Chapter, ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN SECTION Page(s): 111.

Decision rationale: The patient presents with chronic pain affecting the lumbar spine, right shoulder, right wrist and right knee. The current request is for Ultraderm, DOS 2/15/12. I have reviewed the 270 pages that were provided for review and there is no report provided that requests the 4 topical analgesics that have been presented for Independent Medical Review. The utilization review report dated 1/27/14 states that the pain management physician report dated 2/15/12 states, "The patient recently had MRIs of the shoulder, knee and back. The present medication regimen was ineffective. The patient's medications were refilled; MS Contin, Tizanadine, Diclofenac 30% cream and Capsaicin T3 cream. Another cream was added: Amitriptyline 4%, Dextromethorphan 10%, Tramadol 20%, Ultraderm. A urine drug screen was

obtained." The current request is not supported as there is no report available for review that states what the current prescription is for, the quantity of medication prescribed or the dosage amount of the medication. Furthermore, the MTUS guidelines regarding topical analgesics and compounded topical agents state, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." There is no medical information to indicate exactly what is being prescribed and there is no rationale as to why these 4 topical medications are medically necessary. There is no guidelines support or medical evidence for efficacy of Ultram in a dermal patch formulation. The request for Ultraderm is not medically necessary.