

Case Number:	CM14-0117387		
Date Assigned:	08/06/2014	Date of Injury:	07/27/2011
Decision Date:	09/10/2014	UR Denial Date:	07/15/2014
Priority:	Standard	Application Received:	07/25/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 35-year-old male who reported an injury on 07/27/2011. The mechanism of injury was not provided. The diagnoses included lumbar spine herniated disc, cervical radiculitis, and Cervicalgia. Prior treatments included physical therapy. Diagnostic studies included an unofficial EMG/NCV of the lower extremities performed 06/19/2013 that was noted to show bilateral chronic active L5 radiculopathy. Per the 04/02/2014 progress report, the injured worker reported increased pain in the cervical spine, lumbar spine, and left shoulder. Objective findings included decreased range of motion to the cervical and lumbar spines. Current medications included 2 compound creams. The treatment plan included continuing his medications. The rationale for the request was not provided. The Request for Authorization form was not present in the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 10%, Dextromethorphan 10%, Amytriptyline 10%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): Topical Analgesics.

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

Decision rationale: The request for Gabapentin 10%, Dextromethorphan 10%, Amitriptyline 10% is non-certified. The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The guidelines state there is little to no research to support the use of topical antidepressants. Topical Gabapentin is not recommended, as there is no peer reviewed literature to support use. The medical records provided indicate an ongoing prescription for the requested cream since at least 02/19/2014. There is no indication as to the efficacy of the medication. Nonetheless, the requested cream contains at least 1 drug that is not recommended. Therefore, use of the requested cream is not supported. As such, the request for Gabapentin 10%, Dextromethorphan 10%, Amitriptyline 10% is not medically necessary.