

Case Number:	CM14-0150780		
Date Assigned:	09/19/2014	Date of Injury:	09/13/2001
Decision Date:	10/17/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	09/16/2014

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 Pain Management 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 injured worker is a 62-year-old male who sustained work-related injuries on May 3, 1999 and September 13, 2001. On May 5, 2014, he underwent diagnostic facet blocks in the lumbar area at L4-L5 and L5-S1 bilaterally to which he reported more than 80% improvement. On July 1, 2014, the injured worker presented with complaints of lumbar spine pain that radiates into the bilateral hips and primarily radiates distally to his left leg and foot, causing his left foot to develop numbness. The objective findings did not indicate any abnormalities. The most recent progress notes dated August 12, 2014 documents that the injured worker complained of gastrointestinal upset with use of pain medications. Tramadol extended-release also caused significant drowsiness. The objective findings only indicated vital signs. He also underwent urine drug testing and revealed results consistent with the treatment plan. He is diagnosed with (a) lumbar spine disc protrusion per magnetic resonance imaging, (b) lumbosacral sprain and strain, and (c) unspecified thoracic/lumbosacral neuritis/radiculitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20%/Tramadol 20% compound cream Quantity: 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 Topical Analgesics Page(s): 111-113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicate that topical or compounded medications are considered to be largely experimental in use with few randomized controlled trials that can help determine efficacy or safety. This form of medication is primarily indicated for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, the compounded product contains flurbiprofen, a nonsteroidal anti-inflammatory drug, and according to evidence-based guidelines, topical nonsteroidal anti-inflammatory drugs are primarily indicated for osteoarthritis and tendinitis particularly of the knee or elbow or other joints that are amenable to topical treatment. In this case, the injured worker does not exhibit any of the aforementioned indications. Moreover, with regard to the tramadol component, evidence-based guideline indicates that there is little to no research to support the use of this agent in topical form. Additionally, there is no indication that first-line treatments have been tried and failed. Therefore, the medical necessity of the requested flurbiprofen 20%/tramadol 20% compounded cream is not established.

Amitriptyline 10%/Gabapentin 10%/Dextromethorphan 10% compound cream Quantity:
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 Topical Analgesics Page(s): 111-113.

Decision rationale: According to Chronic Pain Medical Treatment Guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the requested compounded product contains gabapentin. The Chronic Pain Medical Treatment Guidelines indicate that gabapentin is not recommended for topical use as there is no peer-reviewed literature to support its use. Therefore, the medical necessity of the requested amitriptyline 10%/gabapentin 10%/dextromethorphan 10% compound cream is not established.