

Case Number:	CM14-0027813		
Date Assigned:	06/13/2014	Date of Injury:	10/07/2003
Decision Date:	10/07/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	03/03/2014

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 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 45 year old female injured on 10/07/03 due to undisclosed mechanism of injury. Current diagnoses included cervical disc degeneration, lumbar spine disc disorder, and lumbar disc bulge. Clinical note dated 12/04/13 indicated the injured worker presented complaining of cervical spine pain and right shoulder pain especially with movement overhead. The injured worker also complained of lumbar spine pain radiating to bilateral legs. The injured worker reported medications and compound creams were helpful with pain management. Physical examination revealed lumbar spine tenderness in the paraspinal musculature, decreased range of motion secondary to pain, positive straight leg raise to the left lower extremity at 20 degrees, cervical spine tenderness in the paraspinal musculature, decreased range of motion secondary to pain, right shoulder tenderness to the acromioclavicular joint, and positive Neer, Hawkins, and O'Brien. Treatment plan recommendations included continuation of medications and compound creams. Right shoulder autologous stem cell injections in lieu of surgery was requested. Additional requests were illegible. The initial request for Cyclobenzaprine 10% Tramadol 10% 15g was initially non-certified on 02/14/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 10% Tramadol 10% 15gm: Upheld

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

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 records that these types of medications have been trialed and/or failed. The guidelines require that all components of a compounded topical medication be approved for transdermal use. Cyclobenzaprine and Tramadol have not been approved for transdermal use. There is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, this compound containing Cyclobenzaprine 10% Tramadol 10% 15 gm cannot be deemed as medically necessary as it does not meet established and accepted medical guidelines.