MAXIMUS Federal Services

Case Number:	CM14-0039728		
Date Assigned:	06/27/2014	Date of Injury:	12/08/2008
Decision Date:	08/19/2014	UR Denial Date:	03/06/2014
Priority:	Standard	Application Received:	04/04/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California and Nevada. 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 73 year old female injured on 12/08/08 due to undisclosed mechanism of injury. Current diagnoses included cervical spine sprain/strain with MRI finding of disc bulges at C4 through C7, status post right shoulder surgery with residual pain, and allergic reaction to tramadol and Tylenol with codeine. Clinical note dated 12/28/14 indicated the injured worker presented complaining of cervical spine and right shoulder pain. The injured worker reported right shoulder pain with numbness and tingling into the right hand and neck pain described as sharp and burning with numbness and tingling into the right arm. Physical examination revealed deep tendon reflexes 2/4 in the upper extremities, decreased range of motion of the lumbar spine with tenderness over the paraspinal muscles at the distal one third of the lumbar spine, decreased range of motion of the right shoulder, tenderness over acromioclavicular joint and posterior supraspinatus and infraspinatus muscle group of the right shoulder. Medications included Norco 5-325mg twice daily, Naprosyn 550mg twice daily, compounded medications, and omeprazole. The initial request for compound amitriptyline /tramadol/ dextromethorphan and compound gabapentin / Ketoprofen/ Lidoderm was non-certified on 03/06/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound: Amitriptyline/Tramadol/Dexteomethorphan: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical medications Page(s): 111/127.

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, 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, California Medical Treatment Utilization Schedule (MTUS), Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. All of components have yet to 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 Compound: Amitriptyline/Tramadol/Dexteomethorphan cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Compound: Gabapentin/Ketoprofen/Lidoderm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical medications Page(s): 111/127.

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, 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, California Medical Treatment Utilization Schedule (MTUS), Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. All of components have yet to 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 Compound: Gabapentin/Ketoprofen/Lidoderm cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.