MAXIMUS Federal Services

Case Number:	CM14-0044675		
Date Assigned:	07/02/2014	Date of Injury:	12/13/2012
Decision Date:	08/22/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/11/2014

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 and Rehabilitation and is licensed to practice in 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 records, presented for review, indicate that this 62-year-old female was reportedly injured on 12/13/2012. The mechanism of injury was not listed in the records reviewed. The most recent progress note, dated 2/6/2014, indicated that there were ongoing complaints of neck, right shoulder, low back, and right leg pain. The physical examination demonstrated cervical spine positive tenderness to palpation at the cervical insertion of the paracervical muscles and trapezius bilaterally. Base of the cervical spine was tender. Limited range of motion with pain. Right shoulder had positive tenderness to palpation at the acromioclavicular joint, Sternoclavicular joint and anterior capsule on the right. Positive Neer's sign. Positive Hawkins sign and positive impingement. Limited range of motion with crepitus. Lumbar spine had positive tenderness in the paralumbar muscles with limited range of motion. Positive muscle spasm on the right. Slight decrease of ankle jerk reflex on the right. Decreased plantar strength on the right. Decreased posterior/lateral foot and heel sensation. Positive sciatic stretch sign. Positive straight leg raise on the right 40-50 in both supine and seated position. Left side straight leg does produce back pain at 70-75 in both seated and supine position. No recent diagnostic studies are available for review. Previous treatment included medication, and conservative treatment. A request was made for amitramadol-DM transderm 240 mg, gaba/keto/lido transderm 240 mg, and was not certified in the pre-authorization process on 3/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitramadol-DM Tramsderm 240 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: MTUS guidelines state that topical analgesics are largely experimental and that any compound product that contains at least one drug (or drug class,) that is not recommended, is not recommended. Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. After review of the medical records provided, there was determination of any documented failure of first-line treatment modalities such as antidepressants/anticonvulsants. As such, this request is not medically necessary.

Gabaketolido Transderm 240 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: MTUS guidelines state that topical analgesics are largely experimental and that any compound product that contains at least one drug (or drug class), that is not recommended, is not recommended. Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. After review of the medical records provided,there was no identifiable documented failure of first-line treatment options such as antidepressants or anticonvulsants. As such, this request is not medically necessary.