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| Case Number: | CM14-0065518 | | |
| Date Assigned: | 07/11/2014 | Date of Injury: | 01/26/2012 |
| Decision Date: | 09/17/2014 | UR Denial Date: | 04/29/2014 |
| Priority: | Standard | Application Received: | 05/08/2014 |

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 Texas. 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 22-year-old male who reported an injury on 01/26/2012. The mechanism of injury is not provided within this review. His diagnoses were noted to be lumbar spine disc protrusion, left foot/ankle sprain/strain, and lumbar spine radiculopathy. Prior treatments were noted to be physical therapy, acupuncture, and medications. Diagnostic tests were noted to be electromyography. The subjective complaints of the injured worker were noted on a Primary Treating Physician's Progress Report. Low back pain was noted to be a 4/10, ankle pain a 6/10, and foot pain a 6/10. The objective findings were vital signs within normal limits; alert and oriented x3; tenderness with palpation; and pain with range of motion. The treatment plan was for medications and creams. The provider's rationale was noted within the treatment plan. A Request for Authorization form was not provided within the review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flubi 20%, Trama 20%, Cyclo 4% cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. These are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas, with advantages that they include lack of systemic side effects. The agents are compounded as monotherapy or in combination for pain control. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. In addition, it is not noted within the Primary Treating Physician's Progress Report that the injured worker has had a failed trial of antidepressants or anticonvulsants. The provider's request does not indicate a dosage frequency, not does it provide an area of local application. Lastly, it does not indicate a quantity. As such, the request is not medically necessary and appropriate.

Gaba 10%, Amitrip 10%, Dextro 10% cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. These are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas, with advantages that they include lack of systemic side effects. The agents are compounded as monotherapy or in combination for pain control. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The medication requested contains Gabapentin. This is not recommended by the guidelines topically. Because one ingredient is not recommended, the entire cream is not recommended. In addition, it is not noted within the Primary Treating Physician's Progress Report that the injured worker has had a failed trial of antidepressants or anticonvulsants. The provider's request does not indicate a dosage frequency, not does it provide an area of local application. Lastly, it does not indicate a quantity. As such, the request is not medically necessary and appropriate.