

Case Number:	CM14-0066447		
Date Assigned:	07/11/2014	Date of Injury:	02/16/2014
Decision Date:	08/13/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	05/09/2014

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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 30 year old male with a work injury dated 2/16/14. The diagnoses include diagnoses include cervical sprain/strain, thoracic sprain/strain, right shoulder sprain/strain, chest pain, anxiety, depression, and insomnia. Under consideration are requests for retroactive Flurbiprofen/Tramadol/Cyclobenzaprine 20/20/4% Cream 240g and also Retroactive Amitriptyline/Dextromethorphan/Gabapentin 10/10/10% Cream 240g. There is a primary treating physician (PR-2) document dated 3/12/14 that states that the patient complains of right shoulder pain, constant neck pain, intermittent right-sided chest pain, anxiety, depression, insomnia, and nervousness. On physical examination there is tenderness to palpation in the cervical spine, especially at the C5-6 and C6-7 spinous processes. An examination reveals full range of motion with pain. The shoulder examination reveals tenderness and spasms in the bilateral upper trapezii and rhomboid. The right pectoralis, longissimus dorsi, rotator cuff, and bicipital groove all revealed tenderness. There is also tenderness with spasm in the right carpal bones and tenderness to palpation in the interosseous spaces at the volar and dorsal aspect. There is a positive right Tinel's, Phalen's, and reverse Phalen's. The treatment plan includes topical creams.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retroactive Flurbiprofen/Tramadol/Cyclobenzaprine 20/20/4% Cream 240g for date of service 03/12/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The request for Retro Compound Medications- Flurbiprofen/Tramadol/Cyclobenzaprine 20/20/4% Cream 240g is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Furthermore, the guidelines state that there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Additionally the documentation does not indicate inability to tolerate oral medications. For these reasons the request for Retro Compound Medications- Flurbiprofen/Tramadol/Cyclobenzaprine 20/20/4% Cream 240g is not medically necessary.

Retroactive Amitriptyline/Dextromethorphan/Gabapentin 10/10/10% Cream 240g for date of service 03/12/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: The request for retroactive Amitriptyline/Dextromethorphan/Gabapentin 10/10/10% Cream 240g is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines state that topical Gabapentin is not recommended as there is no peer-reviewed literature to support use. The documentation does not indicate that the patient is unable to take oral medications. For these reasons the request therefore for retroactive Amitriptyline/Dextromethorphan/Gabapentin 10/10/10% Cream 240g is not medically necessary.