

Case Number:	CM14-0125347		
Date Assigned:	08/11/2014	Date of Injury:	08/04/2008
Decision Date:	04/24/2015	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/06/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 41 year old female, who sustained an industrial injury on 08/04/2008. Initial complaints reported included lumbar spine pain. The initial injury was not found in the medical records. Treatment to date has included medications, conservative care, physical therapy, MRI of the lumbar spine (02/03/2009, 06/30/2010), MRI of the cervical spine (06/30/2010), acupuncture, electrodiagnostic testing of the bilateral lower extremities, cortisone injection to the right wrist (01/25/2011), right shoulder arthrogram (06/29/2011), right shoulder surgery (06/21/2013), right carpal tunnel syndrome (03/23/2012), and sleep study. At the time of the request for authorization, the injured worker complained of acid reflux, gastropathy, constipation and diarrhea. Diagnoses included abdominal pain rule out ulcer/anatomical alteration, acid reflux, constipation/diarrhea rule out irritable bowel syndrome, and sleep disorder rule out sleep apnea. The treatment plan included laboratory testing and urine toxicology screening, EKG/ECG, abdominal ultrasound, cardio-respiratory testing, sleep study with CPAP titration, and medications (Dexilant, simethicone, probiotics) and gastrointestinal consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

TOPICAL CREAM 210 GM (GABAPENTIN 10 PERCENT, AMITRIPTYLINE 10 PERCENT) DEXTROMETHORPHAN 10 PERCENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111 AND 113.

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

Decision rationale: The patient presents with unrated lower back pain. The patient's date of injury is 08/04/08. Patient is status post multiple level lumbar laminectomy at a date unspecified. The request is for TOPICAL CREAM 210GM - GABAPENTIN 10 PERCENT, AMITRIPTYLINE 10 PERCENT, DEXTROMETHORPHAN 10 PERCENT. The RFA was not provided. Physical examination dated 01/21/15 reveals a well healed mid-line surgical scar in the lumbar region, tenderness to palpation and spasm of the lumbar paraspinal muscles, and positive straight leg raise test on the left. The patient is currently prescribed Soma and Norco. Diagnostic imaging was not included. Patient's current work status was not provided. MTUS page 111 of the chronic pain section states the following regarding topical analgesics: "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one 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 regard to the requested compounded topical cream containing Gabapentin, Dextromethorphan, and Amitriptyline, the requested cream contains ingredients which are not supported by guidelines as topical agents. Gabapentin is not supported as a topical agent. MTUS guidelines indicate that any compounded medication which contains an unsupported ingredient is not substantiated. Therefore, the request IS NOT medically necessary.