

Case Number:	CM14-0193414		
Date Assigned:	12/01/2014	Date of Injury:	04/21/2014
Decision Date:	01/15/2015	UR Denial Date:	11/01/2014
Priority:	Standard	Application Received:	11/18/2014

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 Interventional Spine, and is licensed to practice in California. 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 46-year-old female with a date of injury of 04/21/2014. According to doctor's first report from 08/27/2014, the patient presents with neck pain that radiates into the bilateral upper extremities with numbness and weakness. Examination revealed decreased range of motion of the cervical spine by 20% in all planes. There is bilateral tenderness in the C1 to C7 spinous processes. Bilateral motor strength is 4/5. There is tenderness in the tuberosity of the left shoulder and deltoid. The listed diagnoses are: 1. Sprain/strain of neck. 2. Shoulder sprain/strain. 3. Disorder of bursa/tendons of left shoulder. Treatment plan is for x-rays of the bilateral shoulders, initial FCE, ortho referral, cardiorespiratory test, physical therapy 3 times 4 weeks, and acupuncture 2 times 4. The patient is to return to regular work on 09/30/2014. This is a retrospective request for gabapentin/amitriptyline/dextromethorphan and flurbiprofen/tramadol (DOS 09/02/2014). The medical file provided for review does not include a progress report from which the date the medication was dispensed. Utilization review denied the topical creams on 11/01/2014. Treatment reports 07/26/2014 through 08/27/2014 were provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Gabapentin/Amitriptyline/Dextromethorphan (DOS: 9/2/14):
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 creams, Topical analgesics Page(s): 111.

Decision rationale: This patient presents with upper extremity complaints. This is a retrospective request for gabapentin/amitriptyline/dextromethorphan (DOS 09/02/2014). Dextromethorphan is a cough suppressant and Amitriptyline is a tricyclic antidepressant. There is no documentation that the patient has been diagnosed with depression or chronic cough. The MTUS Guidelines page 111 has the following regarding topical creams, "Topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety." MTUS states that many agents are compounded for pain control including antidepressants and that there is little to no research to support their use. MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." Dextromethorphan is not discussed in MTUS for topical application but MTUS specifically states that anti-depressants such as Amitriptyline are not recommended. Gabapentin is also not recommended in any topical formulation. The requested compound cream is not medically necessary.

Retrospective request for Flurbiprofen/Tramadol (DOS: 9/2/14): 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 Creams, Topical Analgesics Page(s): 111.

Decision rationale: This patient presents with continued upper extremity complaints. This is a retrospective request for flurbiprofen/tramadol (DOS 09/02/2014). The MTUS Guidelines page 111 has the following regarding topical creams, "Topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." For Flurbiprofen, which is a nonsteroidal anti-inflammatory agent, "the efficacy in clinical trials for this treatment modality has been inconsistent, and most studies are small and of short duration...Indications for use are osteoarthritis and tendinitis (in particular, that of the knee and elbow) or other joints that are amenable to topical treatment." In this case, the patient does not meet the indication for Flurbiprofen and Tramadol has not been tested for transdermal use. The requested topical compound cream is not medically necessary.