

Case Number:	CM15-0107627		
Date Assigned:	06/12/2015	Date of Injury:	05/21/2009
Decision Date:	07/22/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	06/04/2015

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: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 46-year-old female, with a reported date of injury of 05/21/2009. The diagnoses include failed back syndrome, bilateral left lumbar radiculopathy/lumbar sacral neuritis, degenerative lumbosacral spine/disc/facet disease, severe low back pain and left leg pain, and failed therapies for pain control. Treatments to date have included left lumbar transforaminal epidural injection on 02/27/2015; an MRI of the lumbar spine showed left lumbar radiculopathy and degenerative disc disease; removal of bilateral dorsal column stimulator lead in the lumbar spine; temporary implant of the bilateral lumbar spinal cord stimulator lead on 11/26/2014; radiofrequency of right lumbar facet neurotomy on 05/13/2014; and oral medications. The progress report dated 04/27/2015 is handwritten and somewhat illegible. The report indicates that the injured worker reported 60% relief after the epidural injection. The pain in the lumbar spine was rated 3-5 out of 10. The pain medications helped increase her activities of daily living. The objective findings include decreased range of motion of the lumbar spine and L3-L5 paraspinal muscle spasms. The treating physician requested a pain cream: Amitriptyline 5%/Baclofen 2%/Clonidine 0.2%/Gabapentin 10%/Lidocaine 5%. The rationale for the request was not indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain cream (ABCGL) Amitriptyline 5%, Baclofen 2%, Clonidine 0.2%, Gabapentin 10%, Lidocaine 5% #1: 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): 111-113.

Decision rationale: The request is not medically necessary. The use of topical analgesics is largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when antidepressants and anticonvulsants have failed. Topical baclofen is not recommended as per MTUS guidelines as there is no peer-reviewed literature to support its use. According to MTUS, topical gabapentin is not recommended as there is no peer-reviewed literature to support use. Any compounded product that contains at least one drug that is not recommended is not recommended. Therefore, the request is considered not medically necessary.