

Case Number:	CM15-0164328		
Date Assigned:	09/01/2015	Date of Injury:	05/23/2013
Decision Date:	10/19/2015	UR Denial Date:	07/23/2015
Priority:	Standard	Application Received:	08/21/2015

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: 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 female, who sustained an industrial injury on May 23, 2013. She reported low back pain with bilateral lower extremity pain, tingling and numbness. The injured worker was diagnosed as having lumbosacral disc protrusion. Treatment to date has included physical therapy, chiropractic care and work restrictions. Currently, the injured worker continues to report low back pain with bilateral lower extremity pain, tingling and numbness. The injured worker reported an industrial injury in 2013, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on January 26, 2015 revealed low back pain with bilateral lower extremity pain, tingling and numbness. It was noted work restrictions were unchanged. Evaluation on March 9, 2015, was hand written and difficult to decipher. Retrospective review of Flurbiprofen/Tramadol 20%/20%, DOS: 01/09/15, DOS: 12/12/14 and Retrospective review of Gabapentin/Amitriptyline 10%/10%, DOS: 01/09/15, DOS: 12/12/14 were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective review of Flurbiprofen/Tramadol 20%/20%, DOS: 01/09/15, DOS: 12/12/14:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) and on the Non-MTUS FDA, compounded topical anesthetic creams.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Based on the 01/26/15 progress report provided by treating physician, the patient presents with low back pain with bilateral lower extremity pain, tingling and numbness. The request is for RETROSPECTIVE REVIEW OF FLURBIPROFEN/TRAMADOL 20%/20%, DOS: 01/09/15, DOS: 12/12/14. Patient's diagnosis on 01/26/15 includes lumbosacral disc protrusion. Treatment to date has included physical therapy, chiropractic care, lumbar ESI and work restrictions. The patient is off-work, per 01/26/15 report. MTUS, Topical Analgesics Section, p111 states: "Topical Analgesics: Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Gabapentin: Not recommended. Baclofen: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." Topical NSAIDs are indicated for peripheral joint arthritis/tendinitis, MTUS page 29 guidelines state that Flurbiprofen topical is recommended only as an option in patients who have not responded or are intolerant to other treatments. Indications are osteoarthritis, fibromyalgia, chronic non-specific back pain and it is also helpful for chronic neuropathic and musculoskeletal pain. Retrospective progress reports with the request were not provided, nor RFA's. Provided progress reports were handwritten and difficult to interpret. No medical rationale was provided, nor discussion of where this topical will be applied. In this case, the requested topical contains Flurbiprofen which is indicated for the treatment of peripheral joint arthritis/tendinitis, which the patient does not present with. MTUS page 111 also states that if one of the compounded topical product is not recommended, then the entire product is not. In this case, the requested topical compound contains Tramadol, which is not supported for topical use in lotion form, per MTUS. This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.

Retrospective review of Gabapentin/Amitriptyline 10%/10%, DOS: 01/09/15, DOS: 12/12/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) and on the Non-MTUS FDA, compounded topical anesthetic creams.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Based on the 01/26/15 progress report provided by treating physician, the patient presents with low back pain with bilateral lower extremity pain, tingling and numbness. The request is for RETROSPECTIVE REVIEW OF GABAPENTIN/AMITRIPTYLINE

10%/10%, DOS: 01/09/15, DOS: 12/12/14. Patient's diagnosis on 01/26/15 includes lumbosacral disc protrusion. Treatment to date has included physical therapy, chiropractic care, lumbar ESI and work restrictions. The patient is off-work, per 01/26/15 report. MTUS, Topical Analgesics Section, p111 states: "Topical Analgesics: Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Gabapentin: Not recommended. Baclofen: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." Retrospective progress reports with the request were not provided, nor RFA's. Provided progress reports were handwritten and difficult to interpret. No medical rationale was provided, nor discussion of where this topical will be applied. In this case, the requested topical compound contains Gabapentin, which is not supported for topical use in lotion form, per MTUS. With regard to Amitriptyline, none of the guidelines discuss or support anti-depressants for topical use. MTUS page 111 states that if one of the compounded topical product is not recommended, then the entire product is not. This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.