

Case Number:	CM15-0046082		
Date Assigned:	03/18/2015	Date of Injury:	12/05/2013
Decision Date:	04/24/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/11/2015

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 60 year old male, who sustained an industrial injury on 12/05/2013. He was diagnosed as having other unspecified back disorder, lumbago, thoracic or lumbosacral neuritis or radiculitis and sciatica. Treatment to date has included medications, physical therapy, and acupuncture and modified work. Per the Primary Treating Physician's Progress Report dated 11/3/2014, the injured worker reported pain in the low back with radiation to his legs, rated as 6/10. Physical examination revealed tenderness over the paraspinal area bilaterally with abnormal range of motion of the lumbar and thoracic spine. Straight leg raise is positive on the left. The plan of care included continuation of medications and drug screening. Authorization was requested for Flurbiprofen Tramadol cream and Gabapentin Amitriptyline Dextromethorphan cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen Tramadol cream 20/20% 1 every morning as needed- 1 tube: Upheld

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

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

Decision rationale: This patient has a date of injury of 12/5/13 and presents with low back pain that radiates into the lower extremities. The current request is for FLURBIPROFEN, TRAMADOL CREAM 20/20% 1 EVERY MORNING AS NEEDED- 1 TUBE. The MTUS Guidelines p 111 has the following regarding topical creams, topical analgesics are largely experimental and used with few randomized control 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 non-steroidal 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 amendable to topical treatment." In this case, the patient does not meet the indication for this topical medication as he does not present with osteoarthritis or tendinitis symptoms but suffers from back pain. Given the patient does not meet the indication for the use of a topical NSAID; the entire compounded cream is rendered invalid. This topical compound medication IS NOT medically necessary.

Gabapentin-Amitrip Dextromet Cream 10/10/10% 1 three times a day as needed- 1 gram:
Upheld

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

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

Decision rationale: This patient has a date of injury of 12/5/13 and presents with low back pain that radiates into the lower extremities. The current request is for GABAPENTIN-AMITRIP DEXTROMET CREAM 10/10/10% 1 THREE TIMES A DAY AS NEEDED-1GRAM. The MTUS Guidelines p 111 has the following regarding topical creams, topical analgesics are largely experimental and used with few randomized control 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." Gabapentin is not recommended in any topical formulation; therefore, the entire compounded cream is rendered invalid. This topical compound medication IS NOT medically necessary.