MAXIMUS Federal Services

Case Number:	CM15-0055899		
Date Assigned:	04/01/2015	Date of Injury:	03/10/2005
Decision Date:	05/07/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	03/24/2015

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
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 56 year old male, who sustained an industrial injury on 3/10/2005. The current diagnoses are status post cervical fusion (8/23/2012), right upper extremity pain, possible cervical radiculopathy versus upper extremity nerve entrapment, status post right medial epicondylectomy, status post right radial nerve release, status post first rib resection, and medication-induced gastritis. According to the progress report dated 11/12/2014, the injured worker complains of neck pain with radiation into his right shoulder and down his entire right upper extremity, with numbness in his hands and fingers. He notes persistent tightness in his neck and swelling in his right arm and hand. The pain is rated 5/10 with medications and 7/10 without. The current medications are Gabapentin, Prilosec, Tramadol, Oxycodone and Tylenol. Treatment to date has included medication management, X-rays, computed tomography scan, electrodiagnostic studies, physical therapy, pain injection, nuclear medicine bone scan, TENS unit, acupuncture, chiropractic, right shoulder steroid injection, and stellate ganglion block. The plan of care includes Gabapentin 10% /Transderm gel, PCCA Anhydrous Lipoderm cream, and Poloxamer 407 powder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Gabapentin 10%, Transderm gel 30g (DOS 10/15/14): 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 analgesics Page(s): 111-113.

Decision rationale: The MTUS chronic Pain Treatment Guidelines state that topical analgesics are experimental due to limited studies being available to prove their safety and effectiveness with chronic pain. Specifically, topical antiepilepsy drugs such as gabapentin are not recommended for the treatment of chronic pain, as there is insufficient data to support its general use. In the case of this worker, topical gabapentin was recommended, which is not recommended. Also, the documentation reveals that the worker was also using oral gabapentin, which is redundant. Therefore, the request is not medically necessary at this time.

Retrospective PCCA Anhydrous Lipoderm cream 19.8g (DOS 10/15/14): 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 Analgesics Page(s): 111-113.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines state that topical analgesics, especially compounded and/or combination analgesic products, are experimental as they do not have sufficient evidence to support their general use. PCCA Anydrous Lipoderm cream is a base for facilitating the administration of multiple medications in one medium (for combination products). In the case of this worker, as the other topical analgesics were not approved, in the opinion of the reviewer, there would be no medical need for the Lipoderm cream. The request is not medically necessary.

Retrospective Poloxamer 407 powder 3g (DOS 10/15/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Compounded drugs.

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

Decision rationale: The MTUS Chronic Pain Treatment Guidelines state that topical analgesics, especially compounded and/or combination analgesic products, are experimental as they do not have sufficient evidence to support their general use. Polaxamer is a an ingredient for use in the administration of topical medications in one medium (for combination products). In the case of this worker, as the other topical analgesics were not approved, in the opinion of the reviewer,

there would be no medical need for the Poloxamer 407 powder. The request is not medically necessary.