

Case Number:	CM14-0122717		
Date Assigned:	08/08/2014	Date of Injury:	06/27/2003
Decision Date:	10/07/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/04/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Texas. 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 injured worker is a 53 year old male who was injured at work on 06/ 27/2003. The injured worker complains of intermittent dull, throbbing, sharp and achy 7/10 lower back pain that increases with prolonged standing, and movement. The pain radiates to the lower extremities; it is associated with numbness, tingling and weakness in the legs. He had mild improvement following epidural steroid injection, and chiropractic care. However the pain later worsened as a result of which he was prescribed topical analgesics. His physical examination revealed difficulty rising from a seat, erect posture, stiff slow and guarded movement, decreased lumbar range of motion, mild bilateral tenderness of the lumbar spine area, spasms of the lumbar spine area, positive straight leg raise on both sides. There was increased pain during toe and heel walk. The injured worker has been diagnosed of Lumbar sprain/strain and bilateral lower extremity radiculopathy, multilevel disc protrusions, osteophytes, canal stenosis, and retrolisthesis. At dispute are retrospective request for 1 prescription for Amitrip/Trama/Dextro 4/20/10%, 240 gm between 06/26/2014 and 06/26/2014; and the Retrospective request for 1 prescription for Cyclo/Keto/Lido 03/20/6.15 - 240 gm between 06/06/2014 and 06/26/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for 1 prescription for Amitrip/Trama/Dextro 4/20/10%, 240 gm between 06/26/2014 and 06/26/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded topical medications - Topical analgesics.

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

Decision rationale: The medical records provided for review do not indicate a medical necessity for 1 prescription for Amitrip/Trama/Dextro 4/20/10%, 240 gm between 06/26/2014 and 06/26/2014. Neither Amitriptyline, nor Tramadol, nor Dextromethorphan, is a recommended topical analgesic. The MTUS does not recommend the use of any compounded product that contains at least one drug (or drug class) that is not recommended. The request for Retrospective request for 1 prescription for Amitrip/Trama/Dextro 4/20/10%, 240 gm between 06/26/2014 and 06/26/2014 is not medically necessary.

Retrospective request for 1 prescription for Cyclo/Keto/Lido 03/20/6.15 - 240 gm between 06/06/2014 and 06/26/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded topical medications - Topical analgesics.

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

Decision rationale: The medical records provided for review do not indicate a medical necessity for retrospective request for 1 prescription for Cyclo/Keto/Lido 03/20/6.15 - 240 gm between 06/06/2014 and 06/26/2014. Neither Cyclobenzaprine, nor Ketoprofen is a recommended topical analgesic. The MTUS does not recommend the use of any compounded product that contains at least one drug (or drug class) that is not recommended. The request for Retrospective request for 1 prescription for Cyclo/Keto/Lido 03/20/6.15 - 240 gm between 06/06/2014 and 06/26/2014 is not medically necessary.