

Case Number:	CM14-0092213		
Date Assigned:	09/12/2014	Date of Injury:	04/05/2011
Decision Date:	10/10/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/18/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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:

According to the records made available for review, this is a 47-year-old female with a 4/5/11 date of injury, status post L5-S1 decompression and fusion 10/2/12, and status post right shoulder arthroscopy subacromial decompression, SLAP lesion repair, distal claviclectomy/mumford procedure 3/23/14. At the time (5/8/14) of request for authorization for Amitriptyline 10% / Dextromethorphen 10% / Gabapentin 10%, there is documentation of subjective (5/10 right shoulder pain, 7/10 left shoulder pain, 8/10 low back pain with right lower extremity symptoms, and 6/10 thoracic pain with radiation to right lateral chest wall) and objective (right shoulder abduction 100 degrees, forward flexion 100 degrees, tenderness left shoulder diffusely, limited range of motion left shoulder, tenderness lumbar spine, lumbar range of motion limited with pain, positive straight leg raise on right, diffuse tenderness thoracic spine, and tenderness right lateral chest wall) findings, current diagnoses (3 weeks status post right shoulder surgery, status post remote lumbar fusion L5-S1, chronic low back pain with radiculopathy, thoracic pain, and right anterior lateral chest wall pain), and treatment to date (surgery and home exercise program).

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline 10% / Dextromethorphen 10% / Gabapentin 10%: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of 3 weeks status post right shoulder surgery, status post remote lumbar fusion L5-S1, chronic low back pain with radiculopathy, thoracic pain, and right anterior lateral chest wall pain. However, the requested Amitriptyline 10% / Dextromethorphen 10% / Gabapentin 10% contains at least one drug (Gabapentin) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Amitriptyline 10% / Dextromethorphen 10% / Gabapentin 10% is not medically necessary.