MAXIMUS Federal Services

Case Number:	CM15-0065342		
Date Assigned:	04/13/2015	Date of Injury:	10/01/2007
Decision Date:	05/11/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	04/07/2015

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: North Carolina
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 55 year old male, who sustained an industrial injury on October 1, 2007. The injured worker had reported neck and back pain. The diagnoses have included cervical spine degenerative disc disease with radiculopathy, lumbar spine degenerative disc disease with radiculopathy, failed back surgery syndrome, failed cervical spine surgery syndrome, thoracic degenerative disc disease, thoracic radiculopathy and depression. Treatment to date has included medications, radiological studies, ice/heat treatment, injections, psychological evaluation, a home exercise program and a cervical and lumbar fusion. Current documentation dated February 25, 2015 notes that the injured worker reported ongoing neck and back pain. Examination of the cervical spine revealed tenderness, spasms, and a decreased range of motion. There was also tenderness and spasms noted in the thoracolumbar area with diffuse trigger points. Examination of the lumbar spine revealed tenderness, spasticity and a positive straight leg raise test bilaterally. Range of motion was also noted to be restricted. The treating physician's plan of care included a request for Flurbiprofen / Cyclobenzaprine / Gabapentin / Lidocaine / Prilocaine cream and Androderm patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen / Cyclobenzaprine / Gabapentin / Lidocaine / Prilocaine cream 1.6 #1: Upheld

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

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

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication contains multiple ingredients, which are not indicated per the California MTUS for topical analgesic use. Therefore the request is not certified and not medically necessary.

Androderm patch #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation physician desk reference.

Decision rationale: The ACOEM, California MTUS and the ODG do not specifically address the requested service. Per the physician desk reference, the medication is indicated in the use of testosterone replacement in patients with documented low testosterone and symptoms. There is no documentation of such a condition in the provided clinical notation and therefore the request is not certified and not medically necessary.