

Case Number:	CM14-0122191		
Date Assigned:	08/06/2014	Date of Injury:	09/17/2013
Decision Date:	08/24/2015	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/01/2014

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. 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

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 66 year old male, who sustained an industrial injury on 9/17/2013. The injured worker was diagnosed as having left hip trochanteric bursitis, possible groin strain, possible spine strain, possible lumbar radiculopathy, and moderate left hip osteoarthritis. Treatment to date has included physical therapy and medications. On 6/27/2014, the injured worker complained of worsening left hip and low back pain. He reported constant numbness and tingling to his left lower extremity and rated pain 10/10. He was not working or attending therapy. Current medication use included Tamsulosin. The treatment plan included physical therapy, Cyclobenzaprine, Gabapentin, and Tramadol ER. Additional compound medications were prescribed for topical application. His work status was total temporary disability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gaba/Tramadol Cream, 240gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): s 111 and 113. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Compound Drugs.

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

Decision rationale: Regarding the request for Gaba/Tramadol Cream, 240gm, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Tramadol is not supported in topical form. Regarding topical Gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient, despite guideline recommendations. In light of the above issues, the currently requested Gaba/Tramadol Cream, 240gm is not medically necessary.

GCT Cream 240gm: Upheld

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

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

Decision rationale: Regarding the request for GCT Cream 240gm, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Tramadol is not supported in topical form. Muscle relaxants drugs are not supported by the CA MTUS for topical use. Regarding topical Gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient, despite guideline recommendations. In light of the above issues, the currently requested GCT Cream 240gm is not medically necessary.