

Case Number:	CM13-0011829		
Date Assigned:	06/06/2014	Date of Injury:	07/21/2009
Decision Date:	07/11/2014	UR Denial Date:	08/08/2013
Priority:	Standard	Application Received:	08/15/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 69-year-old male who reported an injury on 07/21/2009 due to cumulative trauma. The clinical note dated 03/11/2014 noted the injured worker presented with neck and upper bilateral extremity pain. He stated that he continued to experience a decrease in overall strength in the upper extremities, primarily in the hands. Upon examination of the cervical spine, there was a mild torticollis, a positive head compression sign, positive Spurling's, tenderness and muscle spasm, pain on scapular retraction, and the levator scapula had a knot. Cervical spine range of motion was 25 degrees of forward flexion, 20 degrees of extension, and 20 to 25 degrees of tilt and rotation to the right and left. The injured worker had diminished reflexes in the biceps and triceps, as well as weakness in the deltoid musculature, biceps and wrists extensors. There were diminished sensation to the lateral aspect of the deltoid, and the thumb opposition was slightly weak. The diagnoses included cervical and trapezius myofascial pain, cervical discopathy, left greater than right bilateral shoulder impingement syndrome, bilateral upper extremities overuse tendinitis, and left greater than right epicondylitis. Prior treatment included physical therapy and medication management. The current treatment plan included conservative therapy, diclofenac, and transdermal creams. The provider recommended amitriptyline/dextromethorphan/tramadol 4/10/20% with 30 gm, and diclofenac/flurbiprofen 10/25% with 30gm. The providers rationale was not included. The Request for Authorization form was not included in the medical documents.

IMR ISSUES, DECISIONS AND RATIONALES

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

**AMITRIPTYLINE/DEXTROMETHORPHAN/TRAMADOL 4/10/20% 30GM
DISPENSED ON 03/13/2012: Upheld**

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: B LeBon, G Zeppetella, IJ Higginson - Journal of pain and symptoms, 2009 - Elsevier.

Decision rationale: The request for retrospective amitriptyline/dextromethorphan/tramadol 4/10/20% 30gm is non-certified. The California MTUS Guidelines state that topical compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded drug that contains at least 1 drug that is not recommended is not recommended. It is also stated that many agents are compounded as monotherapy or in combination for pain control including opioids and antidepressants; however, there is little to no research to support the use of many of these agents. The guidelines note muscle relaxants are not recommended for topical application and there is limited evidence to support antidepressant or opioids for topical use. Additionally, peer-reviewed literature further state that there is a deficiency of higher quality evidence on the role of topical opioids and that more robust primary studies are required to inform practice recommendations. Amitriptyline is not recommended for topical application. As the requested topical compound contains agents which are not supported by the guidelines, the compound is also not supported. The providers request did not indicate the site the cream was intended for and the frequency. As such, the request Amitriptyline/Dextromethorphan/Tramadol 4/10/20% 30gm dispensed on 03/13/2012 is not medically necessary and appropriate.

DICLOFENAC/FLURBIPROFEN 10/25% 30GM DISPENSED ON 03/13/2012: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The request for retrospective diclofenac /flurbiprofen 10/25% 30 gm is non-certified. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesia is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded drug that contains at least 1 drug that is not recommended is not recommended. The guidelines further state, that diclofenac is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment, such ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. There was a lack of significant objective examination findings to support the possible

pathology to warrant the medication. The injured worker is not documented to have signs or diagnostics equivalent to osteoarthritis pain. The provider's request does not indicate the site at which the cream was intended for. The requested cream contains at least one drug that is not recommended; therefore, its use is not supported by guidelines. As such, the request for Diclofenac/Flurbiprofen 10/25% 30gm dispensed on 03/13/2012 is not medically necessary and appropriate.