MAXIMUS Federal Services

| Case Number: | CM14-0019932 | | |
|---|---|---|---|
| Date Assigned: | 04/28/2014 | Date of Injury: | 09/22/2004 |
| Decision Date: | 07/08/2014 | UR Denial Date: | 02/13/2014 |
| Priority: | Standard | Application Received: | 02/18/2014 |

## 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 Physical Medicine and Rehabilitation 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 59 year old male who reported an injury on 09/22/2004. The mechanism of injury was not provided. Per the 01/14/2014 clinical note, the injured worker reported low back, right shoulder, and bilateral knee pain with stabbing pain in the hamstrings. Physical examination of the right shoulder showed tenderness to palpation of the acromioclavicular joint and flexion of 140 degrees. The lumbar spine examination showed spasm and tenderness in the paralumbar musculature and a negative straight leg raise. Examination of the knees showed tenderness to palpation of the medial and lateral joint lines, as well as over the patellar tendon. The injured worker's diagnoses included right shoulder sprain/strain, status post left knee arthroscopic surgery, bilateral knee chondromalacia, bilateral knee internal derangement, right knee medial meniscus tear, left trochanteric bursitis, lumbar sprain/strain, and lumbar spine discopathy. Treatment to date included physical therapy and medications. The provider recommended additional physical therapy, as well as Norco 10/325mg, Amitramadol-DM Ultracream #240gm, and Gabaketolido cream #240gm. The request for authorization forms were submitted on 01/14/2014.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**8 PHYSICAL THERAPY SESSIONS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend 9-10 visits over 8 weeks for myalgia and myositis with the fading of treatment frequency, plus active self-directed home physical medicine. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The medical records provided for review indicate the injured worker was participating in initial physical therapy. It is unclear how many visits had been completed. The injured worker reported he was attending the gym and using the elliptical machine with good results. It appears the injured worker is benefiting from a self-directed home exercise program. The medical necessity for additional physical therapy was not established. In addition, the submitted request does not specify the site or frequency of treatment. As such, the request is not medically necessary and appropriate.

**AMITRAMADOL-DM ULTRACREAM #240GM:** Upheld

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

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

**Decision rationale:** The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Also, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The active ingredients in amitramadol-DM ultracream include amitriptyline 4%, tramadol 20%, and dextromethorphan 10%. The MTUS Chronic Pain Guidelines further state, there is little to no research to support the use of compounded topical agents containing opioids or antidepressants. The medical records submitted did not indicate the injured worker was experiencing any neuropathic pain. In addition, the submitted request does not specify the site of application. As such, the request is not medically necessary and appropriate.

**GABAKETOLIDO CREAM #240GM:** Upheld

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

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

**Decision rationale:** The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They

are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Also, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The active ingredients in gabaketolido cream include gabapentin 6%, ketoprofen 20%, and lidocaine HCl 6.15%. Ketoprofen is not currently FDA approved for a topical application. The only commercially approved topical formulation of lidocaine is Lidoderm. Topical gabapentin is not recommended because there is no-peer reviewed literature to support its use. Gabaketolido cream contains drugs that are not recommended for topical use; therefore, it is not recommended. In addition, the submitted request did not specify the site of application. As such, the request is not medically necessary and appropriate.

**NORCO 10/325MG #60 WITH 3 REFILLS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-81.

**Decision rationale:** In regards to opioid management, the MTUS Chronic Pain Guidelines state there should be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. The medical records provided indicate the injured worker has an ongoing prescription for norco. Per the 01/14/2014 clinical note, the injured worker reported significant ongoing pain. The provider noted that norco provided relief and allowed the injured worker to perform some activities of daily living. A urine specimen was collected to monitor medication use. It is unclear the results of the drug screen. An adequate assessment of pain relief, functional status, and side effects was not present. As such, the request is not medically necessary and appropriate.