

Case Number:	CM14-0034356		
Date Assigned:	06/20/2014	Date of Injury:	09/22/2009
Decision Date:	07/22/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/19/2014

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 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 41-year-old female who reported injury 09/22/2009. The mechanism of injury was not provided within the medical records. The clinical note dated 03/11/2014 indicated diagnoses of bilateral upper extremity overuse tendonitis and carpal tunnel syndrome and status post left carpal tunnel release. The injured worker reported persistent right and left wrist pain, as well as ongoing numbness and tingling. She rated her pain at a constant 5/10. On physical examination of the bilateral shoulders, there was full range of motion with pain, abduction was 75 degrees and produced discomfort. The acromioclavicular joints were tender and slightly prominent bilaterally. Examination of the wrists and hands revealed full range of motion, with pain. The injured worker's Tinel sign was positive. The injured worker had forearm tenderness. Sensation in the bilateral median nerve below the elbow was slightly diminished. The injured worker's grip strength on the right hand was 22 kg. The injured worker measured 10/11/11 on the right dominant extremity, and 10/9/9 on the left. There were no signs of wrist instability. The injured worker's prior treatments included diagnostic imaging, surgery, and medication management. The injured worker's medication regimen included Amitramadol-DM Ultra Cream, gabapentin, naproxen, and gaba/keto/lido cream. The provider submitted requests for Amitramadol-DM, Gabapentin, Naprosyn and Gabaketolido. A Request for Authorization was not submitted for review to include the date treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitramadol-DM Ultracream 240 grams (Amitriptyline 4% / Tramadol 20% / Dextromethorpan 10%): Upheld

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

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

Decision rationale: The California MTUS guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficiency or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. 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. 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 use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. There is lack of documentation of efficacy and functional improvement with the use of this medication. In addition, there was lack of documentation submitted to indicate trials of antidepressants and anticonvulsants had failed. Furthermore, there is little to no research to support the use of many of these agents. Additionally, the request did not indicate a quantity or frequency for the medication. Therefore the request for Amitramadol-DM Ultra Cream 240 g is not medically necessary.

60 Tablets of Gabapentin 300mg with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific anti-epilepsy drugs Page(s): 18.

Decision rationale: The California MTUS guidelines recognize gabapentin/Neurontin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. There was lack of documentation of efficacy and functional improvement with the use of this medication. In addition, the request did not provide a frequency for the gabapentin. Therefore, the request for gabapentin is not medically necessary.

60 Tablets of Naprosyn 500mg with 3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 73.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines state Naprosyn is indicated for Osteoarthritis or ankylosing spondylitis. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. The documentation submitted did not indicate the injured worker had findings that would support she was at risk for osteoarthritis or ankylosing spondylitis. In addition, the injured worker has been prescribed this medication since at least 01/2014. This exceeds the guidelines recommendation of shortest duration. Additionally, there is lack of documentation of periodic lab monitoring of a CBC and chemistry profile including liver and renal function tests within 4 to 8 weeks after starting NSAID therapy. Furthermore, the request did not indicate a frequency or quantity for the medication. Therefore the request for naproxen is not medically necessary.

Gabaketolido Cream 240 grams (Gabapentin 6%/Ketoprofen 20%/Lidocaine HCL 6/15%:
Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state topical analgesic are 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. The guidelines also indicate any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. The guidelines state Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. The guidelines state Lidocaine is approved only as the lidoderm patch. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. There is no peer reviewed literature to support the use of gabapentin and ketoprofen is not currently FDA approved for a topical application. Any compounded product that contains at least 1 drug or drug class that is not recommended, is not recommended. In addition, lidocaine is approved only as the Lidoderm Patch. Therefore, any other topical lidocaine medication is not recommended. Furthermore, the request did not indicate a quantity or frequency for the medication. Therefore, the request for Gabaketolido Cream 240 g is not medically necessary.