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| Case Number: | CM14-0036968 | | |
| Date Assigned: | 06/25/2014 | Date of Injury: | 10/17/2011 |
| Decision Date: | 07/25/2014 | UR Denial Date: | 03/17/2014 |
| Priority: | Standard | Application Received: | 03/27/2014 |

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 & 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 32-year-old female with a reported date of injury on 10/17/2011. The mechanism of injury was not provided within the documentation available for review. The injured worker presented with burning pain in the left knee rated at 8/10. In addition, the injured worker complained of left hand and wrist pain associated with occasional numbness and tingling rated at 6/10. Upon physical examination, the injured worker's elbow and forearm and wrist range of motion presented within normal limits. Previous physical therapy and conservative care was not provided within the documentation available for review. The injured worker's diagnoses included mild left De Quervain's tenosynovitis, status post carpal tunnel release, left hand wrist overuse tendinopathy, left knee chondromalacia, and status post left knee arthroscopy on 09/14/2013. The injured worker's medication regimen included Naproxen, Ultram, Norco, and topical analgesics. The request for authorization for Amitramadol DM Transderm 4/20/10% 240 gm and Gabaketolido Transderm 6/20/6.15% cream 240 gm was not submitted. The rationale for the request was not provided within the documentation available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitramadol DM Transderm 4/20/10% 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 Topical Analgesics, Tramadol Page(s): 111-112.

Decision rationale: The California MTUS Guidelines state that topical analgesics are recommended as an option. Although they are largely experimental in use with few randomized controlled trials to determine effectiveness or safety. Topical analgesics are 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. 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. Amitramadol DM contains amitriptyline and tramadol. Amitriptyline is a tricyclic antidepressant. Tramadol is a centrally-acting synthetic opioid analgesic and is not recommended as a first-line oral analgesic. There is a lack of documentation related to the injured worker's failure in the trial of antidepressants and anticonvulsants. In addition, the documentation provided for review indicates the injured worker has been utilizing topical analgesics prior to 12/2013. There is a lack of documentation related to the therapeutic benefit and functional increase related to the long-term use of topical analgesics. The clinical information lacks documentation related to neuropathic pain and functional deficits. In addition, the request as submitted failed to provide frequency and specific site at which the topical analgesic was to be utilized. Therefore, the request for Amitramadol DM transderm 4/20/10% 240 grams is not medically necessary and appropriate.

Gabaketolido Transderm 6/20/6.15% cream 240gm: 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 rationale: Topical analgesics are recommended as an option as indicated. The California MTUS Guidelines recommend topical analgesics as an option although topical 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. Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. 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. Gabaketolido contains gabapentin, ketamine and lidocaine. The guidelines recommend Lidocaine for localized peripheral pain after there has been evidence of a trial of first-line therapy. Topical Lidocaine in the formulation of a dermal patch called Lidoderm has been designated for orphan status by the FDA for neuropathic pain. No other commercially-approved topical formulation of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. In addition, the guidelines state that Gabapentin is not recommended. According to the guidelines, Ketamine is only recommended for treatment of neuropathic pain in refractory cases

in which all primary and secondary treatment have been exhausted. Topical Ketamine has only been studied for use in non-controlled studies for CRPS I (Complex Regional Pain Syndrome) and postherpetic neuralgia. There is a lack of documentation related to the injured worker's functional deficits. The clinical information provided for review lacks documentation of failed conservative care to include physical therapy, antidepressants or anticonvulsants. In addition, the guidelines state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines do not recommend Lidocaine, Gabapentin, or Ketamine. In addition, the clinical information indicates the injured worker has utilized topical analgesics prior to 12/2013. The therapeutic and functional benefit in the long-term use of topical analgesics is not provided within the documentation available for review. In addition, the request as submitted failed to provide frequency and specific site at which the topical analgesic was to be utilized. Therefore, the request for Gabapentolido transderm 6/20/6.15% cream 240 gm is not medically necessary.