

<b>Case Number:</b>	CM14-0042216		
<b>Date Assigned:</b>	06/30/2014	<b>Date of Injury:</b>	10/24/2006
<b>Decision Date:</b>	08/26/2014	<b>UR Denial Date:</b>	03/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/09/2014

### 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 California and Washington. 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 45-year-old female who reported an injury on 10/24/2006 due to continuous trauma. Diagnoses include Right De Quervain's tenosynovitis and ulnar impaction in the right wrist. Prior diagnostic studies include an electromyogram and a nerve conduction velocity study demonstrating bilateral carpal tunnel syndrome, moderate on the right and mild on the left. Prior treatment included a right wrist brace and a splint to wear on her thumb, medications, work restrictions, acupuncture, and bilateral carpal tunnel injections. No surgical history was submitted with documentation for this review. The injured worker complained of bilateral wrist and hand pain rated as constant and moderate to severe in intensity. On physical examination dated 05/16/2012, there were positive Tinel's signs bilaterally over the ulnar and medial nerve, as well as over the right cubital tunnel. Medications included omeprazole, naproxen, tramadol, acetaminophen, Vicodin and topical creams. A request was submitted for Amitramadol DM, amitriptyline 4%, tramadol 20%, and dextromethorphan 10% transdermal 240 mg patch, Omeprazole 20 mg, Naprosyn 500 mg, and Gabapentin 6%, ketoprofen 20%, and lidocaine 6.15% transdermal patch 240 grams. The rationale for the request was not provided with the documentation that was submitted for this review. The Request for Authorization Form was not provided with documentation submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Amitramadol-DM (Amitriptyline 4%/Tramadol 20% Dextromethorphan 10%)  
Transderm 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 Page(s): 111.

**Decision rationale:** The request for Amitramadol-DM (Amitriptyline 4%/Tramadol 20% Dextromethorphan 10%) Transderm 240gm is not medically necessary. According to the California MTUS Guidelines, they state topical analgesics are largely experimental in use with few random controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There was no documentation of neuropathic pain on physical examination that was submitted for review. There is also a lack of a more current clinical examination for subjective and objective information. In addition, the frequency and area of the body the medication was to be applied to was not provided in the request was submitted. As such, the request is not medically necessary.

**Omeprazole 20mg #100 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 GI symptoms and cardiovascular risk Page(s): 68.

**Decision rationale:** The request for Omeprazole 20mg #100 with 3 refills is not medically necessary. The California MTUS Guidelines recommend, for GI symptoms, that it be determined if the patient is at risk for a gastrointestinal event, which would be taking into consideration the age, if over age of 55, history of peptic ulcers, GI bleeding or perforation, or any concurrent use of aspirin, corticosteroids, and/or anticoagulants. There is no current subjective or objective documentation that was provided with the documentation submitted for review. There is a lack of information indicating the injured worker is at risk or currently has gastrointestinal symptoms. In addition, there was no frequency listed in the request for the proposed medication. As such, the request is medically necessary.

**Naprosyn 500mg #100 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): 67.

**Decision rationale:** The request for Naprosyn 500mg #100 with 3 refills is medically necessary. According to California MTUS Guidelines, it is recommended that nonsteroidal anti-

inflammatory drugs are recommended at the lowest dose for the shortest period of time in patients with moderate to severe pain. The injured worker complained of wrist pain. The ranges of motion for the wrists and the hands were all documented as normal. The efficacy of the medication was not provided and there is a lack of a recent and comprehensive evaluation of the injured worker that was submitted for review. Also, there is no frequency listed on the request for the proposed medication. Therefore, the request is medically necessary.

**Gabketolido (Gabapentin 6%/Ketoprofen 20%/Lidocaine 6.15%) Transderm 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 Analgesic Page(s): 111-113.

**Decision rationale:** The request for Gabketolido (Gabapentin 6%/Ketoprofen 20%/Lidocaine 6.15%) Transderm 240gm is medically necessary. According to the California MTUS Guidelines, topical analgesics are recommended as an option and are largely experimental in use with few random controlled trials to determine the efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interaction, and no need to titrate. Guidelines also indicate the only supported formulation of Lidocaine is in the form of Lidoderm. Gabapentin is not supported by guidelines in the topical form. The injured worker had complained of bilateral wrist and hand pain, but there is no current documentation subjectively or objectively that was submitted with the documentation for review. In addition, there is no frequency or body location for the proposed request. As such, the request is medically necessary.