

<b>Case Number:</b>	CM14-0055137		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	04/10/2007
<b>Decision Date:</b>	11/05/2014	<b>UR Denial Date:</b>	04/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2014

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 50-year-old male who reported an injury on 04/10/2007. The injured worker had diagnosis of cervical discopathy, cervical herniated nucleus pulposus and stenosis at C3-4 and C4-5, lumbar discopathy, plantar fasciitis, sleeping problems, and major depressive disorder. Past treatments included medications and urine drug screen. Diagnostic studies and surgical history were not provided. On 02/07/2014, the injured worker complained of severe low back pain which he rated a 9/10 with radiation to the lower extremities. He had constant severe neck pain which he rated an 8/10 to 9/10 with constant radiation to the upper extremities. Exam of the cervical spine revealed a positive Spurling's maneuver. There was tenderness and muscle spasm. Range of motion of the cervical spine revealed forward flexion was 25 degrees; extension was 20 degrees; and tilt and rotation to the right and left was 20 to 25 degrees with significant increase in pain. There was tenderness to the paraspinous musculature of the lumbar region. Midline tenderness was noted in the lumbar spine. The sciatic nerve compression was positive. Lumbar range of motion revealed flexion at 15 degrees, extension was 10 degrees, rotation right was 20 degrees, rotation left was 15 degrees, tilt right was 10 degrees, and tilt left was 10 degrees. There were spasms in the lumbar range of motion. A urinalysis was collected on 11/15/2013, which showed Hydrocodone and Hydroprmorphone, which was not present. The request is for retrospective request for medications Amitriptyline/Tramadol/Dextromerthorphan and Gabapentin/Ketoprofen/Lidocaine (duration unknown and 2-3 times day) dispensed on 02/28/14 for treatment of neck, lumbar, bilateral lower extremity and psyche. The rationale was not provided. The Request for Authorization form was not provided within the documentation submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for medications Amitriptyline/Tramadol/Dextromerthorphan; Gabapentin/Ketoprofen/Lidocaine (duration unknown and 2-3 times day) dispensed on 02/28/14 for treatment of neck, lumbar, bilateral lower extremity and psyche: Upheld**

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

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

**Decision rationale:** The request for retrospective request for medications Amitriptyline/Tramadol/ Dextromerthorphan; Gabapentin/Ketoprofen/Lidocaine (duration unknown and 2-3 times day) dispensed on 02/28/14 for treatment of neck, lumbar, bilateral lower extremity and psyche is not medically necessary. The injured worker has a history of back pain. The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state that there is little to no research to support the use of many agents compounded for topical use for pain control, such as non-steroidal anti-inflammatory drugs (NSAIDs), opioids, Capsaicin, local anesthetics, and antidepressants. Any compounded product that contains at least one drug that is not recommended is not recommended. More specifically, the guidelines indicate that Ketoprofen is not currently FDA approved due to the high incidence of photo contact dermatitis. Gabapentin is not recommended as there is no peer-reviewed literature to support use. The guidelines indicate that topical lidocaine is only recommended to treat neuropathic pain in the formulation of the Lidoderm patch and no other commercially approved topical formulations of lidocaine, such as creams, are indicated. As the guidelines state there is little to research to support use of compounded opioids and antidepressants as topical products, the ingredients Tramadol and Amitriptyline are not supported. In addition, the guidelines specifically do not recommend topical use of Ketoprofen, Gabapentin, and lidocaine, except in the form of the Lidoderm patch. Therefore, as the requested compounded products contain these drugs, the compounds are also not supported. As such, this request is not medically necessary.