

<b>Case Number:</b>	CM14-0086599		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	11/29/2011
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 & Rehabilitation and is licensed to practice in California. 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 58-year-old male who reported an injury after he fell 11/29/2011. The clinical note dated 04/28/2014 indicated diagnoses of severe central canal stenosis at L1-2, L2-3 and L4-5, moderate central stenosis at L3-4, multilevel lumbar degenerative disc disease with history of L4-5 discectomy in 2006, bilateral lower extremity radiculopathy with severe neural foraminal stenosis left L4-5 and left L5-S1 chronic pain syndrome with opioid dependency and situational depression and anxiety secondary to chronic pain. The injured worker reported severe low back pain and bilateral lower extremity pain right greater than left and complained of burning pain affecting both feet. The injured worker reported sharp pain to his low back with weakness in both lower extremities that worsened with being upright as well as with prolonged sitting. The injured worker reported difficulty with walking and standing. The injured worker reported the pain was reduced by lying flat; however, he had difficulty with all activities. The injured worker reported mood changes, depression and anxiety which had affected his interpersonal relationship. The injured worker also reported right upper extremity pain. The injured worker rated his pain 6/10 to 7/10 with medication, without medication he rated his pain 10/10. The injured worker reported 30% to 40% improvement with pain control as a result of his fall. The injured worker reported he was able to perform his activities of daily living; however, he had difficulty performing any increase of activity. The injured worker reported with medication he was able to get up out of his wheelchair a few times per day, without medication he would be 100% confined to his wheelchair. The provider reported the injured worker showed no evidence of drug-seeking behavior and had utilized these medications appropriately and had a signed opioid agreement. The provider also noted the urine drug screening had showed evidence of compliance with prescribed medication. The injured worker's prior treatments included diagnostic imaging, surgery, and medication management. The injured worker's medication

regimen included oxycodone, Norco, Xanax, Adderall and Soma. The provider submitted a request for topical compound. A Request for Authorization was not submitted for review to include the date the treatment was requested.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Topical Compound: Ketamine, Amitriptyline, Gabapentin, Ketorolac, Tromethamine Carbamazepine Clonidine (Unspecified dosage): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-Compound Drug.

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

**Decision rationale:** The request for Topical Compound: Ketamine, Amitriptyline, Gabapentin, Ketorolac, Tromethamine Carbamazepine Clonidine (Unspecified dosage) is not medically necessary. The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketamine which is under study and is only recommended in treatment of neuropathic pain which is refractory to all primary and secondary treatment. It was not indicated if the injured worker had tried and failed antidepressants or anticonvulsants. In addition, ketamine is under study and is only recommended in treatment of neuropathic pain which is refractory to all primary and secondary treatment. In addition, gabapentin is not recommended. There is no peer reviewed literature to support its use. Per the guidelines, any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Moreover, it was not indicated the injured worker had been utilizing this medication or if this was a first time prescription. Additionally, the provider did not indicate a rationale for the request. Furthermore, the request does not indicate a dosage, frequency, or quantity. Therefore, the request for topical compound is not medically necessary.