

Case Number:	CM14-0087640		
Date Assigned:	07/23/2014	Date of Injury:	03/06/2009
Decision Date:	09/22/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/11/2014

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 Management 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:

This is a female patient with a date of injury of March 6, 2009. A utilization review determination dated May 29, 2014 recommends non-certification of Amitriptyline / Tramadol / Dextromethorphan compound 240gm and Gabapentin / Ketoprofen / Lidocaine 240gm. A progress note dated April 15, 2014 identifies subjective complaints of cervical thoracic and lumbar pain with loss of range of motion, mild spasm, and numbness. The patient also complains of bilateral shoulder pain with loss of range of motion and minor spasm. Physical examination identifies limited cervical range of motion due to pain, limited lumbar spine range of motion due to pain, bilateral shoulder range of motion limited due to pain, pain with palpation of the cervical, thoracic, lumbar, and bilateral shoulder, positive edema of the right shoulder, positive sensory loss of the upper and lower extremities, positive trigger points in the cervical thoracic and lumbar spine. Diagnoses included myofascitis-spasm, cervical degenerative disc disease, thoracic degenerative disc disease, lumbar degenerative disc disease, cervical radiculitis, lumbar radiculitis, and the remaining diagnoses are illegible. The treatment plan recommends an orthopedic surgeon consult.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline/Tramadol/Dextromethorphan compound 240gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medicines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: Regarding request for Amitriptyline/Tramadol/Dextromethorphan compound #240gm, the requested topical compound is a combination of Amitriptyline, Tramadol, and Dextromethorphan. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. 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. As such, the currently requested Amitriptyline/Tramadol/Dextromethorphan compound #240gm is not medically necessary.

Gabapentin/Ketoprofen/Lidocaine HCL 240gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medicines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: Regarding request for Gabapentin/Ketoprofen/Lidocaine #240gm, the requested topical compound is a combination of Gabapentin, Ketoprofen, and Lidocaine. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding the use of topical non-steroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards or with the diminishing effect over another two-week period. Regarding the use of topical Gabapentin, the guidelines do not recommend its use. Regarding the use of topical Lidocaine, guidelines state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical Lidocaine. In the absence of clarity regarding those issues, the currently requested Gabapentin / Ketoprofen / Lidocaine #240gm is not medically necessary.

