

<b>Case Number:</b>	CM15-0143928		
<b>Date Assigned:</b>	08/04/2015	<b>Date of Injury:</b>	03/25/2014
<b>Decision Date:</b>	08/31/2015	<b>UR Denial Date:</b>	06/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 63-year-old male who sustained cumulative industrial injuries as an aircraft mechanic on 03-25-2014. According to the Qualified Medical Evaluation report, cumulative trauma claims began in September 4, 1989 through the current injury date to the neck, bilateral shoulder, bilateral hands, fingers, lower back, lower extremities, bilateral knees and both feet. The injured worker was diagnosed with cervical spondylosis with radiculitis, bilateral carpal tunnel syndrome, bilateral shoulder impingement syndrome and left S1 radiculopathy. The injured worker is status post left knee arthroscopy in 2005 and left hand ganglion removal in 2008 and non-industrial surgeries. Treatment to date has included diagnostic testing with recent bilateral shoulder, cervical spine, lumbar spine magnetic resonance imaging (MRIs) in April 2015, surgery, acupuncture therapy, physical therapy, oral medications and topical analgesics. According to the Qualified Medical Evaluation report on January 23, 2015 the injured worker continues to experience neck pain radiating to the bilateral shoulders and down the spine, bilateral hand numbness, pain and locking of the 2nd, 3rd, 4th and 5th fingers, low back pain radiating down the anterior aspect of the bilateral lower extremities, bilateral knee pain worse on the left side and numbness of the toes in both feet. Cervical examination noted decreased range of motion with posterior neck pain. Upper extension motor strength and sensation were intact except for hypoesthesia in the volar aspect of the long and index fingers of the bilateral hands. Tinel's and Phalen's signs of the bilateral wrists were positive with negative Tinel's at the elbows bilaterally. Deep tendon reflexes and vascular of the upper extremities were intact. Bilateral shoulder impingement and supraspinatus signs were present with positive

crepitus bilaterally. There was no acromioclavicular joint tenderness and drop arm and sulcus signs were negative bilaterally. Examination of the bilateral knees demonstrated decreased range of motion with right knee flexion at 105 degrees and extension at 5 degrees and left knee flexion at 120 degrees and extension normal. Patellofemoral crepitation and compression test was positive bilaterally without evidence of effusion. Lumbar spine examination revealed decreased range of motion with guarding on flexion and right lateral bending. Straight leg raise was positive on the left for posterior heel pain and negative on the right. Hamstring tightness was positive on the left and less positive on the right. Fabere was positive for low back pain on the left and less positive on the right. Patrick's was negative bilaterally. Motor strength, sensation to light touch, deep tendon reflexes of the knees and vascular of the bilateral lower extremities were intact. Ankle jerk on the right was 2 plus with an absent ankle jerk on the left. Current medication is noted as Aleve and topical medications. Treatment plan consists of the current request for a retrospective request (01-14-15) for Gabapentin 15%, Amitriptyline 4%, and Dextromethorphan 10%, 180gm with auto refills.

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

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

**Retrospective 01/14/15 - Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10% 180gm with Auto Refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, Capsaicin, topical.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (1) Medications for chronic pain, p60; (2) Topical Analgesics, Page(s): 60, 111-113.

**Decision rationale:** The claimant sustained a work injury in March 2014 and continues to be treated for radiating neck and radiating low back pain, bilateral knee pain, bilateral numbness, locking of the fingers. In January 2015, Aleve was being prescribed. There was a BMI of over 31. There was decreased hand sensation with positive Phalen's and Tinel's testing. There was decreased shoulder range motion with positive impingement testing and crepitus. There was decreased knee range of motion with a non-antalgic gait. Lumbar range of motion was guarded and decreased. Fabere testing was positive for low back pain. Oral Gabapentin has been shown to be effective in the treatment of painful diabetic neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. Its use as a topical product is not recommended. Many agents are compounded as monotherapy or in combination for pain control such as opioids antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonists, adenosine, cannabinoids, cholinergic receptor agonists, GABA agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor. There is little to no research to support the use of many these agents including Dextromethorphan and amitriptyline. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. By prescribing a compounded medication, in addition to increased risk of adverse side effects, it is not possible to determine whether any derived benefit is due to a particular component. In this case, there are other single component topical treatments that could be considered. Guidelines also recommend that when prescribing medications only one medication should be given at a time. This medication was not medically necessary.