

<b>Case Number:</b>	CM15-0173502		
<b>Date Assigned:</b>	09/15/2015	<b>Date of Injury:</b>	10/09/2014
<b>Decision Date:</b>	10/15/2015	<b>UR Denial Date:</b>	08/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/02/2015

### 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 25 year old female who sustained an industrial injury October 9, 2014. According to a primary treating physician's progress report dated April 17, 2015, the injured worker presented for re-evaluation of her low back. She reported the pain is less since her last visit. She is currently undergoing acupuncture and physical therapy with 15 more sessions of acupuncture and 10 of physical therapy to complete. The therapies and medication are all reducing pain and she is working as a receptionist and is able to perform the job with restrictions. Objective findings included; cervical spine tenderness over C5-6 and C6-7 bilaterally with spasm and decreased range of motion; lumbar spine tenderness over L4-5 and L5-S1 bilaterally with decreased range of motion. The physician documented; "urine toxicology dated February 27, 2015, inconsistent with treatment plan-codeine derivatives". A report is present to the medical record. Diagnoses are lumbar spine sprain, strain with radiculitis; muscle spasms; Schmorl's node at level L2; 1.3mm disc protrusion L5-6 per MRI; degenerative disc disease at T12-L1. Treatment plan included recommendation for functional restoration, continue with present therapies, refill Naproxen and Cyclobenzaprine, and prescribed Tramadol. At issue, is the request for authorization for Gabapentin-Amitriptyline-Dextromethorphan and Cyclobenzaprine-Gabapentin-Amitriptyline, date of service April 22, 2015. According to utilization review dated August 3, 2015, the request for Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10% 180gm, DOS: 04-22-2015 is non-certified. The request for Cyclobenzaprine 2%, Gabapentin 15%, Amitriptyline 10% 180gm DOS: 04-22-2015 is non-certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10% 180gm for DOS 4/22/15:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The claimant sustained a work injury in October 2014 and is being treated for neck and low back pain occurring while playing musical chairs at work, landing on her buttocks. When seen, there was decreased and painful lumbar range of motion. There was lumbar paraspinal muscle tenderness with spasms. There was positive straight leg raising. Recommendations included continued physical therapy, chiropractic treatment, and acupuncture. Cyclobenzaprine, Naproxen, and topical creams were prescribed. 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 would be difficult or impossible to determine whether any derived benefit was due to a particular component. In this case, there are other single component topical treatments with generic availability that could be considered. Another compounded topical medication is being prescribed containing gabapentin and amitriptyline and prescribing this medication is duplicative. This medication was not medically necessary.

**Cyclobenzaprine 2%, Gabapentin 15%, Amitriptyline 10% 180gm for DOS 4/22/15:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The claimant sustained a work injury in October 2014 and is being treated for neck and low back pain occurring while playing musical chairs at work, landing on her buttocks. When seen, there was decreased and painful lumbar range of motion. There was

lumbar paraspinal muscle tenderness with spasms. There was positive straight leg raising. Recommendations included continued physical therapy, chiropractic treatment, and acupuncture. Cyclobenzaprine, Naproxen, and topical creams were prescribed. Cyclobenzaprine is a muscle relaxant and there is no evidence for the use of any muscle relaxant as a topical product. 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, prostanooids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor. There is little to no research to support the use of many these agents including amitriptyline. 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. 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 would be difficult or impossible to determine whether any derived benefit was due to a particular component. In this case, there are other single component topical treatments with generic availability that could be considered. Another compounded topical medication is being prescribed containing gabapentin and amitriptyline and prescribing this medication is duplicative. This medication was not medically necessary.