

<b>Case Number:</b>	CM15-0062340		
<b>Date Assigned:</b>	04/08/2015	<b>Date of Injury:</b>	01/24/2011
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	03/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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: California, Washington

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 59 year old female, who sustained an industrial injury on January 24, 2011. The mechanism of injury was not provided. She has reported bilateral knee pain. Diagnoses have included right knee tendinosis, bilateral meniscus tears, and osteoarthritis of the knees. Treatment to date has included medications, physical therapy, left knee surgeries, use of a cane, and imaging studies. The injured worker had atrophy of the quadriceps on the left side and joint line pain. The injured worker had extension leg of 5 degrees. A progress note dated 03/04/2015 indicates a chief complaint of bilateral knee pain. The treating physician documented a plan of care that included medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Panthenol powder:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Vitamin B.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are experimental and are in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed; any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The referenced guidelines do not address Vitamin B. As such, secondary guidelines were sought. Per the Official Disability Guidelines indicate that vitamin B is not recommended for the treatment of chronic pain. The clinical documentation submitted for review failed to provide a rationale for panthenol powder. The request as submitted failed to indicate the frequency, body part, strength and quantity for the powder. Given the above, the request for Panthenol powder is not medically necessary.

**Bupivacaine Powder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, Bupivacaine Page(s): 111, 55. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA.gov.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are experimental and are in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Bupivacaine has been recommended as an alternative to clonidine, however a search of FDA guidelines indicate that Bupivacaine is approved for injection. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guidelines recommendations. There was a lack of documented rationale for the use of bupivacaine. The request as submitted failed to indicate the frequency, body part, strength and quantity for the powder. Given the above, the request for bupivacaine powder is not medically necessary.

**Gabapentin:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

**Decision rationale:** The California MTUS guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. The clinical documentation submitted for review failed to provide documentation of an objective decrease in pain of at least 30% to 50%. There was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency, quantity and strength of the requested medication. Given the above, the request for gabapentin is not medically necessary.

**Amitriptyline powder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Skolnick P (1999) Antidepressants for the new millennium. Eur J Pharmacol 375:31-40.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are experimental and are in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Peer reviewed literature states that while local peripheral administration of antidepressants has been demonstrated to produce analgesia in the formalin model of tonic pain; a number of actions, to include inhibition of noradrenaline (NA) and 5-HT reuptake, inhibition of NMDA, nicotinic, histamine, and 5-HT receptors, and block of ion channels and even combinations of these actions, may contribute to the local peripheral efficacy of antidepressant; therefore the contribution of these actions to analgesia by antidepressants, following either systemic or local administration, remains to be determined. The clinical documentation submitted for review failed to provide the rationale for the requested amitriptyline powder. The request as submitted failed to indicate the frequency, body part, strength and quantity for the powder. Given the above, the request for amitriptyline powder is not medically necessary.

**Mediderm cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Capsaicin, Topical Analgesics, Topical Salicylates Page(s): 28, 111, 105.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety; are primarily recommended for neuropathic pain when trials of

antidepressants and anticonvulsants have failed; any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended; topical salicylates are recommended. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The clinical documentation submitted for review failed to provide documentation of a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the frequency, quantity, and body part to be treated. Given the above, the request for Medi-Derm cream is not medically necessary.