

Case Number:	CM15-0077470		
Date Assigned:	04/28/2015	Date of Injury:	12/08/2002
Decision Date:	06/02/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	04/22/2015

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 54 year old female/male, who sustained an industrial injury on 12/8/02. The diagnoses have included right carpal tunnel syndrome, right wrist strain/sprain, headaches and insomnia. Treatment to date has included medications, left wrist surgery, and conservative care. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI), electromyography (EMG)/nerve conduction velocity studies (NCV) of the upper extremities. Currently, as per the physician progress note dated 3/12/15, the injured worker complains of constant shooting and throbbing pain in the right wrist that was rated 6/10 on pain scale. She reports headaches and loss of sleep due to pain. The objective findings revealed decreased range of motion in the right wrist, Tinel's sign causes pain on the right and there are sleep complaints. The urine drug screen dated 4/18/14, 9/4/14 was consistent with medications prescribed. The physician requested treatments included Retro Amitriptyline 10%/Dextromethorphen 10%/ Gabapentin 10% 210gm (DOS 8-7-14) and Retro Flurbiprofen 20%/Tramadol 20% 210gm (DOS 8-7-14) for pain relief.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Amitriptyline 10%/Dextromethorphen 10%/ Gabapentin 10% 210gm (DOS 8-7-14):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants.

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

Decision rationale: The claimant sustained a work-related injury in December 2002 and continues to be treated for chronic right wrist pain. When seen, pain was rated at 6/10. There was decreased wrist range of motion with positive Tinel's test. 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. Guidelines also recommend that when prescribing medications only one medication should be given at a time. Therefore, this medication was not medically necessary.

Retro Flurbiprofen 20%/Tramadol 20% 210gm (DOS 8-7-14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, NSAIDs (non-steroidal anti-inflammatory drugs).

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

Decision rationale: The claimant sustained a work-related injury in December 2002 and continues to be treated for chronic right wrist pain. When seen, pain was rated at 6/10. There was decreased wrist range of motion with positive Tinel's test. Flurbiprofen is a non-steroidal anti-inflammatory medication. Compounded topical preparations of flurbiprofen are used off-label (non-FDA approved) and have not been shown to be superior to commercially available topical medications such as diclofenac. There is little to no research to support the use of compounded topical Tramadol. 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. Guidelines also recommend that when prescribing medications only one medication should be given at a time. Therefore the requested compounded medication was not medically necessary.

