

Case Number:	CM13-0019280		
Date Assigned:	11/08/2013	Date of Injury:	05/18/2007
Decision Date:	08/11/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/03/2013

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas 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:

The injured worker is a 52-year-old male injured on 05/18/07 while performing his usual and customary job duties locating underground utilities with an air lance and noted sudden and spontaneous onset of burning pain in bilateral hands and elbows. The injured worker underwent surgery to both wrists and elbows in 2008 and 2009. Current diagnoses included ulnar neuropathy, median neuropathy, upper extremities overuse, tendinopathy, bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, and status post bilateral cubital tunnel release. Clinical note dated 06/11/13 indicated the injured worker presented complaining of continued bilateral upper extremities numbness and tingling with occasional shooting pain radiating from the neck into the bilateral upper extremities. The injured worker also continued to complain of bilateral wrist pain localized over the median nerves and low back pain radiating into the lower extremities. Physical examination of the cervical spine revealed tenderness to palpation over the trapezius musculature and reduced range of motion. Physical examination of the bilateral upper extremities revealed tenderness to palpation over the median nerve, positive Tinel and Phalen tests, and tenderness to palpation over the medial epicondyles bilaterally. The injured worker was prescribed acupuncture, Norco 10-325mg, gabketolido, gabapentin 600mg, and meloxicam. The initial request for Norco 10-325mg and gabketolido (gabapentin 6%/Ketoprofen 2%/lidocaine 6.15% was not granted on 08/22/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF NORCO 10/325MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-80, 81, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. The medication request failed to provide a frequency, amount, and number of refills, limiting the ability to assess the medical necessity. Therefore, the medical necessity of Norco 10/325MG cannot be established at this time. The request is not medically necessary.

PRESCRIPTION OF GABKETOLIDO (GABAPENTIN 6%/ KETOPROFEN 2%/ LIDOCAINE 6.15%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The California MTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains gabapentin and Ketoprofen, which have not been approved for transdermal use. Utilization of both oral and topical versions of gabapentin would represent a redundancy in medication administration. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore Gabketolido (Gabapentin 6%/ Ketoprofen 2%/ Lidocaine 6.15%) cannot be recommended as medically necessary, as it does not meet established and accepted medical guidelines. Therefore, the request is not medically necessary.