

<b>Case Number:</b>	CM14-0023512		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	05/23/2012
<b>Decision Date:</b>	10/17/2014	<b>UR Denial Date:</b>	02/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 49-year-old female with an original date of injury on May 23rd , 2012. The worker sustain a crush injury to the left hand and subsequently underwent left thumb open reduction internal fixation immediately after injury. A follow-up x-ray of the left hand on October 8, 2012 demonstrated minimal hypertrophic changes without evidence of fracture or destructive changes. The internal fixation with metal prosthesis was seen through the distal phalanx of the left thumb and there was evidence of bony fusion. The patient has been treated with pain medications and the disputed issue is a request for topical cream consisting of gabapentin, dextromethorphan, and amitriptyline.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 10%/dexamethorphan 10%/amitriptyline 10%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 Analgesics Page(s): 111-113.

**Decision rationale:** On page 113 of the Chronic Pain Medical Treatment Guidelines, the following is stated: "Gabapentin: Not recommended. There is no peer-reviewed literature to

support use." The guidelines further state that if one drug or drug class of a compounded formulation is not recommended, then the entire compounded formulation is not recommended. Therefore, topical gabapentin is recommended as not medically necessary.