

<b>Case Number:</b>	CM14-0026931		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	03/03/2009
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	01/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2014

### 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 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 47-year-old female who reported an injury on 3/3/09. The mechanism of injury was not provided within the documentation. The injured worker was noted to be status post right carpal tunnel release, status post right ulnar transposition surgery, status post lateral epicondylar release, complex regional pain syndrome of the right elbow, anxiety, depression, and sleep disturbance. The injured worker's prior treatments were not provided within the documentation. The most recent clinical evaluation submitted was dated 2/6/13. The injured worker was seen for a follow-up evaluation and had complaints of right shoulder, right elbow, right hand, and right wrist pain. The injured worker rated her pain at a 9/10. The pain was described as occurring 100% of the time. The pain was noted to be aggravated by movement, changing positions, and performing household activities. The injured worker stated pain is better with rest, taking the medication, and using a heating pad. The physical examination indicated slight deficits in right elbow range of motion and right wrist range of motion. She also had slight range of motion deficit with right elbow range of motion. Her brachioradialis reflex was 1+. All other areas of the physical exam were within normal limits. The treatment recommendations included spinal cord stimulator, refills of Soma, Neurontin, Elavil, Percocet, and increase of OxyContin. The injured worker will undergo a functional capacity evaluation prior to spinal cord stimulator trial, and she will undergo a urine toxicology screen to remain in compliance with her current medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**KETOPROFEN/CYCLOBENZAPRINE/GABAPENTIN/TRAMADOL (DURATION AND FREQUENCY UNKNOWN) DISPENSED ON 12/03/12 FOR TREATMENT OF BILATERAL WRIST/HANDS AND RIGHT ELBOW: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112, 121-122.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines indicate that any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The request for topical medication included Ketoprofen, which is not FDA approved. The recommendations state gabapentin is not recommended. The guidelines add there is no peer reviewed literature to support the use of gabapentin topically. The medication requested contains Ketoprofen; this medication is not FDA approved. In addition, the medication requested contains gabapentin; this medication is not recommended by the guidelines. The provider failed to include a duration and frequency with the request. As such, the request is not medically necessary.