

<b>Case Number:</b>	CM14-0200749		
<b>Date Assigned:</b>	12/11/2014	<b>Date of Injury:</b>	10/14/2003
<b>Decision Date:</b>	03/11/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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. 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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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, with a reported date of injury of 10/14/2003. The results of the injury were bilateral upper extremity pain and neck pain. The current diagnoses include persistent neuropathic pain in the bilateral upper extremities, neck pain with myofascial pain and spasms, status post bilateral carpal tunnel release, status post bilateral ulnar nerve release and transposition, and status post repeat ulnar nerve release and transposition on the right. The past diagnoses include status post bilateral carpal tunnel release, status post bilateral ulnar nerve release and transposition, persistent neuropathic pain in the bilateral upper extremities, status post repeat ulnar nerve release and transposition on the right, and chronic postoperative pain. Treatments have included Vicodin, gabapentin, Norco, ibuprofen, Dendracin lotion, a right elbow brace, bilateral carpal tunnel release, and bilateral ulnar nerve release with transposition; repeat right ulnar nerve release and transposition on 01/06/2010, and a right medial epicondylectomy. The progress report dated 11/05/2014 indicates that the injured worker continued to have pain over the cervicothoracic and lumbar spine, limitations with range of motion of the cervical spine, painful numbness and shooting electrical pain in the upper extremities, weakness, and dysesthesias in the upper extremities. She had difficulty with fine motor movements, especially grasping objects. It was noted that the injured worker attempted to discontinue gabapentin, but had increased pain and decreased function, so she restarted the gabapentin. The injured worker rated her pain a 5 out of 10, with medication, and a 9 out of 10, without medication. She noted between 30 to 40% improvement in her pain and a significant improvement in function with her medication regimen. With her medications, the injured worker

is able to participate in her activities of daily living. She mentioned that there was a significant reduction in quality of life without the use of medications. The physical examination showed diffuse myofascial tenderness over the mid to lower cervical paraspinal musculature; spasms into the trapezius, rhomboids, and levator scapulae; decreased cervical range of motion with extension and rotation and lateral bending; tenderness to palpation over the medial epicondylar areas; decreased sensation over the right thumb and medial aspect of the right index finger; decreased grip strength bilaterally; reduced sensory in the fifth digit; and atrophy over the hypothenar pads. The treating physician indicated that the gabapentin was for neuropathic pain, the Norco was for severe pain, and the ibuprofen was for inflammation. The treating physician also noted that the injured worker has signed an opioid agreement, and that a previous urine drug screening has shown evidence of compliance. On 11/19/2014, Utilization Review (UR) denied the request for Amitriptyline 25mg #60, Ibuprofen 800mg #30, and Ketoprofen, Gabapentin, and Lidocaine (KGL) cream #240 grams. The UR physician noted that there is no documentation of how the effectiveness of Amitriptyline will be determined, no documentation of a diagnosis of osteoarthritis, and that Ketoprofen is not FDA approved for topical application.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Amitriptyline 25mg #60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressant.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Amitriptyline.

**Decision rationale:** According to the Official Disability Guidelines, amitriptyline is a tricyclic antidepressant that is recommended for chronic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. I am reversing the previous utilization review decision. Amitriptyline 25 mg is medically necessary.

**Ibuprofen 800mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, NSAID.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

**Decision rationale:** The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The medical record contains no documentation of functional improvement. Ibuprofen 800mg #30 is not medically necessary.

**Ketoprofen, Gabapentin & Lidocain (KGL) cream #240 grams:** Upheld

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

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

**Decision rationale:** The compound contains ketoprofen and is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis and is not recommended by the MTUS. Ketoprofen, Gabapentin & Lidocain (KGL) cream #240 grams is not medically necessary.