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| <b>Case Number:</b>   | CM15-0135888 |                              |            |
| <b>Date Assigned:</b> | 07/23/2015   | <b>Date of Injury:</b>       | 04/26/2010 |
| <b>Decision Date:</b> | 08/20/2015   | <b>UR Denial Date:</b>       | 06/30/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/14/2015 |

### 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: California

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:

This is a 47 year old female with an April 26, 2010 date of injury. A progress note dated June 3, 2015 documents subjective complaints (right elbow pain rated at a level of 7/10), objective findings (tender at both the medial and lateral epicondyle in the right; full range of motion of the right elbow without pain; obvious mid dorsal wrist ganglion cyst that is non tender; increased pain medially with resisted wrist flexion and laterally with resisted wrist flexion), and current diagnoses (ganglion cyst, right wrist; medial epicondylitis; lateral epicondylitis). Treatments to date have included acupuncture, electrical stimulation, medications, and imaging studies. A urine drug screen performed on June 3, 2015 is negative for all substances. The treating physician documented a plan of care that included Flu/Bac/Dex/Men/Cam 120g 20%/5%/0.2%/2%, Amt/Gab/Dex 120mg 10%, and a urine toxicology screen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flu/Bac/Dex/Men/Cam 120g 20%/5%/0.2%/2%:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Flu/Bac/Dex/Men/Cam 120g 20%/5%/0.2%/2%, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants drugs are not supported by the CA MTUS for topical use. Guidelines do not support the use of topical dextromethorphan. As such, the currently requested Flu/Bac/Dex/Men/Cam 120g 20%/5%/0.2%/2% is not medically necessary.

**Amt/Gab/Dex 120mg 10%:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Amt/Gab/Dex 120mg 10%, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. Guidelines do not support the use of topical dextromethorphan. Guidelines do not support the use of topical antidepressants. As such, the currently requested Amt/Gab/Dex 120mg 10% is not medically necessary.

**Urine toxicology screening:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use for Urine drug screen (UDS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
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**Decision rationale:** Regarding the request for a repeat urine toxicology test (UDS), CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, there is no indication that the patient is taking controlled substance medication. Additionally, patient recently underwent a urine drug screen. There is no documentation of risk stratification to identify the medical necessity of drug screening at the proposed frequency. Additionally, there is no documentation that the physician is concerned about the patient misusing or abusing any controlled substances. In light of the above issues, the currently requested repeat urine toxicology test is not medically necessary.