

<b>Case Number:</b>	CM15-0084522		
<b>Date Assigned:</b>	05/06/2015	<b>Date of Injury:</b>	11/19/2010
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	03/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2015

### 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: Utah, Arkansas  
 Certification(s)/Specialty: Family Practice, Sports 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 48-year-old female, who sustained an industrial injury on 11/19/10. The injured worker has complaints of bilateral shoulders and wrist pain. The diagnoses have included bilateral shoulder bursitis; bilateral carpal tunnel syndrome symptoms; bilateral shoulder mild acromioclavicular joint degenerative joint disease and bilateral shoulder superior aspect of the glenoid labrum (SLAP lesions). Treatment to date has included magnetic resonance imaging (MRI) of the thoracic spine on 9/3/13 impression showed degenerative disc disease with small protrusions, T2-3 and T3-4, without evidence for canal stenosis or neural foraminal narrowing at any level; anti-inflammatories and analgesics. The request was for gabapentin 1%/amiytriptyline 1%/bupivacaine 5% in base cream 210 gm quantity 1; flurbiprofen 20%, baclofen 5%/dexamethasone2%, menthol2%, camphor 2%/capsaicin 0.025% base cream 210 gm quantity 1; nerve conduction velocity left upper extremity and a urinalysis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 1%/Amiytriptyline 1%/Bupivacaine 5% in base cream 210 gm Qty 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain chapter - Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, page(s) 111-113.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for a compound medication. The MTUS guidelines discuss compounding medications. The guidelines state that a compounded medicine, that contains at least one drug (or class of medications) that is not recommended, is not recommended for use. The guidelines also state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The MTUS states gabapentin is not recommended as a topical analgesic. Therefore, according to the guidelines cited, it cannot be recommended at this time. The request for the compounded medication is not medically necessary.

**Flurbiprofen 20%, Baclofen 5%/Dexamethasone 2%, Menthol 2%, Camphor 2%/Capsaicin 0.025% base cream 210 gm Qty 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain chapter - Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, page(s) 111-113.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for a compound medication. The MTUS guidelines discuss compounding medications. The guidelines state that a compounded medicine, that contains at least one drug (or class of medications) that is not recommended, is not recommended for use. The guidelines also state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The requested compound therefore, according to the guidelines cited, it cannot be recommended at this time. The request for the compounded medication is not medically necessary.

**EMG (electromyogram) Left Upper Extremity: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 178-179; 303, 309, table 12-8.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neck and Upper Back Complaints; page(s) 177-188.

**Decision rationale:** The current request is for EMG of the left upper extremities. MTUS guidelines were reviewed in regards to this specific case. Clinical documents were reviewed. There is decreased sensation in the left wrist, which would be considered a red flag symptoms noted in the clinical documents, indicating a need for the study. There is clinical documentation evidence for indication of EMG testing, The EMG is indicated as a medical necessity at this time.

**NCV (nerve conduction velocity) Left Upper Extremity:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 178-179; 303, 309, table 12-8.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NCV upper extremities.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Nerve Conduction Velocity (NCV). There is decreased sensation in the left wrist, which would be considered a red flag symptoms noted in the clinical documents, indicating a need for the study. According to the clinical documentation provided and current MTUS guidelines; the request as is, Nerve Conduction Velocity (NCV) is indicated as a medical necessity to the patient at this time.

**Urinalysis:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing, page(s) 43, 76-77.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for urinalysis. There is no indication for the current request. Urinalysis is different from a Urine Drug Screen. According to the clinical documentation provided and current MTUS guidelines; the urinalysis, as requested, is not indicated a medical necessity to the patient at this time.