

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0011048 |                              |            |
| <b>Date Assigned:</b> | 01/28/2015   | <b>Date of Injury:</b>       | 07/06/2014 |
| <b>Decision Date:</b> | 03/18/2015   | <b>UR Denial Date:</b>       | 12/19/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/20/2015 |

### 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: North Carolina, Georgia  
Certification(s)/Specialty: Family Practice

### 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 54 year old female injured worker suffered an industrial injury on 7/6/2014. The diagnoses were right chest sprain, right elbow/forearm sprain, left scapular sprain, and right rotator cuff tear, cervical radiculopathy, lumbar radiculopathy, cervical disc protrusion, and idiopathic peripheral autonomic neuropathy. The diagnostics were x-rays of right shoulder magnetic resonance imaging of the right shoulder and lumbar spine. The treatments were physical therapy and medications. The treating provider reported constant neck pain 6/10 radiating to the bilateral upper extremities with numbness and tingling, frequent low back pain 6/10 radiating to the bilateral lower extremities with numbness and tingling along with right shoulder pain 7/10. On exam there was reduced range of motion to the cervical spine, right shoulder and lumbar spine. The Utilization Review Determination on 12/19/2014 non-certified Gabacyclotram 180GM, citing MTUS.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabacyclotram (gabapentin/cyclobenzaprine/tramadol) 180gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and NSAIDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section 2  
Page(s): 111-113.

**Decision rationale:** CA MTUS recommends limited use of topical analgesics. These are primarily recommended for neuropathic pain with antidepressants and antiepileptics have failed. CA MTUS specifically prohibits the use of combination topical analgesics in which any component of the topical preparation is not recommended. Muscle relaxants in topical formulation are explicitly not approved in the CA MTUS. Gabapentin in topical formulation is explicitly not approved in the CA MTUS. As such, the request for gabapentin/cyclobenzaprine/tramadol is not medically necessary and the original UR decision is upheld.