

Case Number:	CM15-0074097		
Date Assigned:	04/24/2015	Date of Injury:	03/17/2014
Decision Date:	06/11/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/17/2015

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: Emergency 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 36 year old female who sustained an industrial injury on March 17, 2014. She has reported injury to the cervical spine, right shoulder, left shoulder, right wrist, left wrist, right hand, and left hand and has been diagnosed with cervical disc protrusion, cervical radiculopathy, right rotator cuff tear, left rotator cuff tear, right carpal tunnel syndrome, right wrist sprain/strain, left carpal tunnel syndrome, right hand tenosynovitis, and left hand tenosynovitis. Treatment has included acupuncture, medication, and injection. Currently the injured worker has tenderness to palpation of the shoulders, hands, and wrists. The treatment request included Gabapentin 15%/amitriptyline 4%/Dextromethorphan 10% 180 gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 15%/Amitriptyline 4%/Dextromorphan 10%, 180 grams: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49, Chronic Pain Treatment Guidelines Topical Medications Section.

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

Decision rationale: The requested Gabapentin 15%/Amitriptyline 4%/Dextromorphan 10%, 180 grams, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants." The treating physician has documented tenderness to palpation of the shoulders, hands, and wrists. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Gabapentin 15%/Amitriptyline 4%/Dextromorphan 10%, 180 grams is not medically necessary.