

Case Number:	CM13-0071919		
Date Assigned:	01/08/2014	Date of Injury:	11/07/2009
Decision Date:	04/28/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/30/2013

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. The expert reviewer is Board Certified in Internal Medicine, has a subspecialty in Pulmonary Diseases and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 33-year-old male who reported an injury on 11/07/2009. The mechanism of injury was not provided. The documentation indicated the patient was status post open reduction, internal fixation of the left forearm for a Galeazzi fracture on 11/08/2009 with hardware removal on 06/18/2010. Additionally, the patient was status post right distal radius comminuted intra-articular fracture, non-displaced ulnar styloid base fracture, and status post open reduction, internal fixation of distal radius fracture and status post hardware removal. The treatment recommendations as of 11/19/2013 were Napro 15% cream, Omeprazole 20 mg 1 tablet twice a day, Nizatidine 150 mg twice a day, and Norco soft.

IMR ISSUES, DECISIONS AND RATIONALES

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

TOPICAL NAPRO 15% CREAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, NSAIDS Page(s): 111, 67.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines indicate that topical analgesics are largely experimental and are in use with few, randomized controlled

trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical NSAIDs have been shown to be effective for the treatment of osteoarthritis. The only FDA approved topical NSAID is Voltaren. The clinical documentation submitted for review failed to provide the duration the medication had been used. Additionally, there was lack of documentation indicating exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the quantity of medication being requested. The request for Napro 15% cream is not medically necessary and appropriate.