

Case Number:	CM14-0120935		
Date Assigned:	09/29/2014	Date of Injury:	10/02/2013
Decision Date:	11/18/2014	UR Denial Date:	07/02/2014
Priority:	Standard	Application Received:	07/31/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 44-year-old male with a date of injury of 10/02/2013. The listed diagnoses per [REDACTED] are: 1. Left wrist posttraumatic degenerative joint disease following intraarticular distal radius fracture. 2. Right wrist tendinitis with suspicion of TCFF tearing. According to progress report 05/22/2014, the patient presents with continued bilateral wrist pain rated as 6/10 to 8/10 on a pain scale. Examination of the left wrist revealed decreased range of motion, 4/5 strength grip, and tenderness to palpation about the wrist. Examination of the right wrist revealed tenderness to palpation over the flexor tendons as well as tenderness over the joint line in the FCC region. Range of motion is decreased and there is mild swelling about the right wrist. The treater is requesting topical compound cream. Utilization review denied the request on 07/02/2014. Treatment reports from 02/14/2014 through 05/22/2014 were reviewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20%, Tramadol 20% topical compound cream in base 210g, PRN, 3 times per day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Compound Drugs

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

Decision rationale: This patient presents bilateral wrist pain. The treater is requesting a topical compound cream which includes flurbiprofen 20% and tramadol 20%, 110 g total. The treater states that the compound cream is to be applied to the left wrist 3 times a day to help decrease pain and swelling. It was noted the patient cannot tolerate oral medication due to gastrointestinal problems and reflux disease. The MTUS Guidelines page 111 has the following regarding topical creams, "Topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, Tramadol is not recommended as a topical formulation. Therefore, the entire compound cream is not supported. Recommendation is for denial.