

<b>Case Number:</b>	CM14-0027361		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	08/16/2013
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	02/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2014

### 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 and is licensed to practice in Texas. 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 56 year old male who was injured on 08/16/2013 when a heavy conveyor belt fell and landed on him crushing his left wrist. The patient underwent ORIF of left distal forearm on 08/26/2013. Diagnostic studies reviewed include MR arthrogram of the left wrist dated 02/06/2014 revealed minor degenerative changes in the TFC. Progress report dated 02/17/2014 reports the patient complained of left forearm and left wrist pain. He rated his pain level a 3-4/10. On examination of his left wrist, flexion to 65; extension to 40; radial deviation to 10/15; ulnar deviation to 25; pronation to 80; and supination to 80. Diagnoses are left forearm distal fracture of ulnar diaphysis. Prior utilization review dated 02/18/2014 states the request for Flurbitac 100/100 mg is not certified as this medication must be labeled for a specific medical disorder which is not documented in the records provided. Xolido (Lidocaine) is not certified as they are not medically necessary as there is no documented evidence to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MED APPEAL FLURBITAC 100/100 MG #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-69.

**Decision rationale:** Flurbitac is a combination of Ibuprofen and Ranitidine ( as described by the requesting physician).As per the CA MTUS guidelines, Non-steroidal anti-inflammatory medications (NSAIDs), including aspirin and ibuprofen, also are effective for musculoskeletal pain, although they can cause gastrointestinal irritation or ulceration or, less commonly, renal or allergic problems. Studies have shown that when NSAIDs are used for more than a few weeks, they can retard or impair bone, muscle, and connective tissue healing and perhaps cause hypertension. Therefore, they should be used only acutely. Accordingly, the medical necessity of the requested 90 tabs of Flurbitac 100/100mg has not been established according to the guidelines.

**XOLIDO (LIDOCAINE) 2% CREAM:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** According to CA MTUS guidelines, Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Lidocaine is recommended for neuropathic pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). The available medical records document neither the presence of neuropathic pain nor the failure of the first line medications. Therefore, the requested Xolido (Lidocaine) 2% cream is not medically necessary.

**ENOVARX-IBUPROFEN 10% CREAM:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

**Decision rationale:** As per CA MTUS guidelines, Non-steroidal anti-inflammatory drugs as topical analgesics are recommended for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. The medical records do not document any of the above mentioned conditions. Therefore, the medical necessity of the requested Enovarx-Ibuprofen 10% cream has not been established.