

Case Number:	CM14-0046388		
Date Assigned:	07/02/2014	Date of Injury:	06/20/2009
Decision Date:	08/06/2014	UR Denial Date:	04/08/2014
Priority:	Standard	Application Received:	04/15/2014

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 Orthopedic Surgery, 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 injured worker is a 43-year-old female who reported an injury on 06/20/2009 due to an unknown mechanism of injury. The injured worker complained of right wrist pain. On 05/16/2014, the physical examination revealed tenderness on palpation at the biceps groove and subdeltoid bursa. She exhibited limited range of motion with plantar flexion at 70 degrees, dorsiflexion limited to 60 degrees, ulnar deviation limited to 30 degrees, and radial deviation limited to 10 degrees. She had a positive Phalen's sign, and a negative Tinel's sign. There were no diagnostic studies submitted for review. The injured worker had a diagnosis of wrist pain. Past treatment included the use of a TENS unit and medication therapy. The injured worker is on the following medications: Voltaren 1% gel, Lidoderm 5% patch, ibuprofen 600 mg, Pennsaid 2% solution, hydrochlorothiazide 25 mg, and lisinopril 10 mg. The current treatment plan is for 1 Pennsaid 2% solution with 1 refill. The rationale and request for authorization forms were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

One Pennsaid 2% Solution With One Refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines Pain (Chronic).

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

Decision rationale: The request for One Pennsaid 2% Solution with One Refill is not medically necessary. The injured worker has a history of right wrist pain. The California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In addition, in regards to topical NSAIDs the guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. There is no rationale why the injured worker would require a topical cream versus oral medications. In addition, the frequency and location for use of the proposed medication was not provided. Given the above, the request for One Pennsaid 2% Solution with One Refill is not medically necessary.