

Case Number:	CM14-0180485		
Date Assigned:	11/05/2014	Date of Injury:	05/12/2012
Decision Date:	01/02/2015	UR Denial Date:	10/17/2014
Priority:	Standard	Application Received:	10/30/2014

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 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 52 year old female with date of injury 5/12/12. The treating physician report dated 10/07/14 indicates that the patient presents with pain affecting the left wrist. The physical examination findings reveal reduced range of motion of the wrist and hypersensitivity to touch at the dorsal wrist. Right forearm and hand appear very slightly pale and marveled with no swelling. There is atrophy in the dorsal forearm muscles and patient can form a fist. Prior treatment history includes TENS unit; physical therapy; A1 pulley release operation, left ring finger; hardware removal, left wrist; injection; medication; brace and x-rays. MRI findings of the left wrist reveal mild positive ulnar variants associated with what appears to be a triangular fibrocartilage tear, a probable tear of the scapholunate ligament and all degenerative types of chondral cysts in the lunate. The current diagnoses are: 1.Complex regional pain syndrome2.Joint cartilage dis wrist TFC. The utilization review report dated 11/03/14 denied the request for Keta/Bac/Cyclo/Flur/Gaba/Lido 240 gm (retrospective DOS 9/05/14) based on none of these compounds being supported by MTUS for topical use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Keta/Baclo/Cyclo/Flur/Gaba/Lido #240 (retrospective DOS 9/5/14): 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): 113.

Decision rationale: The patient presents with left wrist pain. The current request is for Keta/Bac/Cyclo/Flur/Gaba/Lido 240 gm (retrospective DOS 9/05/14). MTUS guidelines do not support the use of muscle relaxants or antiepileptics for topical use. In this case the treating physician has prescribed a topical analgesic that contains Baclofen, Cyclobenzaprine and Lidoderm, all of which are not recommended per MTUS. There is no information provided to support treatment outside the guidelines. MTUS guidelines state that "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Recommendation is for denial.