

<b>Case Number:</b>	CM15-0001937		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	07/09/2013
<b>Decision Date:</b>	03/09/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: Ohio, North Carolina, Virginia  
Certification(s)/Specialty: Family Practice

### 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 58 year old male, who sustained an industrial injury on July 9, 2013, falling, injuring the right wrist. The injured worker was reported to have a comminuted intra-articular displaced distal radius fracture with an ulnar styloid fracture with a small 0.5cm open area on the volar wrist. The diagnoses have included status post (S/P) right wrist impaction, crush injury in forced palmar flexion, S/P right distal radius open fracture, S/P right distal radius fracture ORIF, S/P right distal ulnar styloid fracture, right forearm loss of supination, right chronic wrist pain, right wrist loss of range of motion, right thumb loss of range of motion, right carpal tunnel syndrome, mild right four fingers intrinsic tightness, S/P right wrist 4 portal arthroscopy, debridement, and synovectomy, and right thumb stenosing tenosynovitis S/P cortisone injection x1. Treatment to date has included irrigation, drainage, and debridement of the right distal radius fracture with an open reduction internal fixation using s distal plate on July 9, 2013, a kenalog injection, activity modification, a night wrist splint, medications, home exercise program, and physical therapy. Currently, the IW complains of pain in the right forearm, thumb, and wrist, numbness of the right thumb, palm, and wrist, burning sensation in the right wrist, hand, and forearm, clicking of the right elbow/forearm, weakness in the right hand, pain in the right shoulder, and severe cramp of the right hand/forearm. An Orthopedic Hand/Plastic & Reconstructive Specialists report dated November 20, 2014, noted a positive median nerve compression test, Tinel's sign, and Phalen's sign, a positive ulnar nerve compression test and Tinel's sign, and chronic pain along the plate distal radius. On this date it was prosed that the injured worker undergo more surgery for ulnar nerve decompression,carpal

tunnel release, wrist flexor tenosynovectomy, neuroplasty of the ulnar nerve, tissue rearrangement, and removal of hardware. The physician has prospectively requested, among other items, a 'wound care cream' presumably for post-operative use. On December 23, 2014, Utilization Review non-certified wound care cream, noting that it was not known if this medication was a compound topical analgesic or a simple skin lotion/ointment, and there was no evidence to support a prescribed cream as opposed to an over the counter medication. The MTUS Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines (ODG) were cited. On January 5, 2015, the injured worker submitted an application for IMR for review of wound care cream.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Wound care cream:** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Forearm, wrist, and hand

**Decision rationale:** Recommended as indicated below. Recommend the following combinations: for chronic wounds, (1) debridement stage, hydrogels; (2) granulation stage, foam and low-adherence dressings; and (3) epithelialization stage, hydrocolloid and low-adherence dressings; and for the epithelialization stage of acute wounds, low-adherence dressings. For specific situations, the following dressings are favored: for fragile skin, low-adherence dressings; for hemorrhagic wounds, alginates; and for malodorous wounds, activated charcoal. [The various stages of wound healing are debridement or the stage in which debridement is required; granulation, in which the wound is recovered by newly formed, pink granular tissue (granulation tissue); and epithelialization, in which keratinocytes migrate across the wound surface.] A moist environment facilitates wound healing more so than allowing the wound to air-dry. There are only weak levels of evidence on the clinical efficacy of modern dressings compared with saline or paraffin gauze in terms of healing, with the exception of hydrocolloids. There was no evidence that any of the modern dressings was better than another, or better than saline or paraffin gauze, in terms of general performance criteria. Hydrocolloid dressings proved superior to saline gauze or paraffin gauze dressings for the complete healing of chronic wounds, and alginates were better than other modern dressings for debriding necrotic wounds. Hydrofiber and foam dressings, when compared with other traditional dressings or a silver-coated dressing, respectively, reduced time to healing of acute wounds. There is no evidence to support claims that specific dressings, such as silver-containing antibacterial dressings, are most appropriate for selected indications, such as care of infected wounds or prevention of infection. (Chaby, 2007) There is no evidence that using tap water to cleanse acute wounds in adults increases infection and some evidence that it reduces it. Drinkable tap water applied topically is as effective as normal saline for cleansing a wound, according to this Cochrane review. Various solutions have been recommended for cleansing wounds, however normal saline has been favored as it is an isotonic solution and does not interfere with the normal healing process. Antiseptic preparations

have been traditionally used, but animal models suggest that antiseptics may actually hinder healing. (Fernandez, 2008) Although wounds may be irrigated with saline or tap water, povidone iodine, detergents, and hydrogen peroxide should be avoided (level of evidence, B). For skin laceration repair, suturing is the preferred technique (level of evidence, C). Compared with sutures, tissue adhesives are comparable in cosmetic results, rates of dehiscence, and the risk for infection (level of evidence, A). To promote wound healing, applying white petrolatum to a sterile wound is as effective as applying an antibiotic ointment (level of evidence, B). Areas of high skin tension, such as over joints, or areas with a thick dermis, such as the back, should be closed with sutures or staples. Areas with low skin tension, such as the face, shin, and dorsal hand, may be repaired with tissue adhesives. Absorbable sutures usually dissolve within 4 to 8 weeks. Rates of wound dehiscence and infection appear similar between absorbable and nonabsorbable sutures, and cosmetic results are also similar between these 2 types of suture. A horizontal mattress suture is usually best for high-tension wounds or wounds with fragile skin, and the vertical mattress technique is best for everting wound edges in anatomic locations which tend to invert, such as the posterior aspect of the neck. Subcuticular running suture is ideal for low-tension, cosmetically important wounds. Tissue adhesive is convenient and may be cost effective because no follow-up for suture removal is necessary. Patients at a higher risk of poor healing, including patients with diabetes, should not receive tissue adhesive. For scalp lacerations less than 10 cm long, strands of hair at least 3 cm in length from opposing sides of the wound may be twisted and fixed with a drop of tissue adhesive to close the laceration. In this instance, because the proposed surgery was a future event, it is presumed that the cream proposed would be to facilitate healing of a surgical wound. The referenced guidelines do not support the use of specific creams to aid in the healing of surgical wounds acutely. Because the request lacks specificity, a wound care cream (unspecified) is not medically necessary.