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| Case Number: | CM15-0019406 | | |
| Date Assigned: | 02/09/2015 | Date of Injury: | 06/11/2013 |
| Decision Date: | 04/02/2015 | UR Denial Date: | 12/31/2014 |
| Priority: | Standard | Application Received: | 02/03/2015 |

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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 30-year-old male who reported an injury on 06/11/2013. The mechanism of injury was not stated. The current diagnoses include right wrist arthralgia, right wrist carpal tunnel syndrome, and right wrist internal derangement. The latest physician progress report submitted for review is documented on 10/20/2014. The injured worker presented for a follow-up consultation. The injured worker noted ongoing right wrist pain. It was also noted that the injured worker would be moving forward with a scheduled surgery in the near future. Upon examination, there was painful and decreased right wrist and hand range of motion with decreased grip strength and mild to moderately decreased sensation to light touch. Recommendations included continuation of Norco 2.5/325 mg and topical creams. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20%/Tramadol 20% in Mediderm Base: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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

Decision rationale: California MTUS Guidelines state any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The only FDA approved topical NSAID is Diclofenac. Flurbiprofen is not recommended for topical use. There is also no strength or frequency listed. As such, the request is not medically appropriate.

Gabapentin 10% / Amitriptyline / 10%/Dextromethorphan 10% In Mediderm Base:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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

Decision rationale: California MTUS Guidelines state any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Gabapentin is not recommended as there is no peer reviewed literature to support its use as a topical product. There is also no strength or frequency listed. Given the above, the request is not medically appropriate.