

Case Number:	CM15-0131250		
Date Assigned:	07/17/2015	Date of Injury:	09/15/2013
Decision Date:	08/14/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/07/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 37 year old female who sustained an industrial injury on 09/15/2013. The injured worker was diagnosed with keloid formation and rule out nerve entrapment. The injured worker is status post excision of volar ganglion cyst right wrist on May 28, 2014. Treatment to date has included diagnostic testing with recent Electromyography (EMG)/Nerve Conduction Velocity (NCV) on March 12, 2015, surgery, physical therapy/hand therapy, home exercise program and medications. According to the primary treating physician's progress report on March 25, 2015, the injured worker continues to experience right wrist pain. The injured worker rates her pain level at 7/10. The injured worker also reports difficulty sleeping due to pain. Examination demonstrated tenderness at the volar and first dorsal aspect of the right wrist with large keloid hypertrophic incision scar with contracture and painful terminal range of motion. Tinel's and Phalen's signs were positive. There was a weak grip without evidence of instability. No apparent swelling was noted and skin was warm with normal color and turgor. Significant hypersensitivity was documented with dysesthesia of the right thumb. Current medications are listed as Tramadol ER 150mg, Lunesta, Cyclobenzaprine, Fenoprofen, Ondansetron, and Prevacid. Treatment plan consists of cortisone injection, dermatology consultation, home exercise program and the current request for Flurbiprofen 10%/Capsaicin 0.025% cream and Lidocaine 6%/Hyaluronic acid 0.2% gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 10%/Capsaicin 0.025% cream #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: Regarding the request for topical Flurbiprofen 10%/Capsaicin 0.025% cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. The guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there's no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of topical flurbiprofen compound cream. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, as patient was previously prescribed Nalfon for anti-inflammatory and pain treatment. In the absence of clarity regarding those issues, the currently requested topical compound containing flurbiprofen is not medically necessary.

Lidocaine 6%/Hyaluronic acid 0.2% gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine Page(s): 112.

Decision rationale: Regarding request for topical Lidocaine 6%/Hyaluronic acid 0.2% gel, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the first line therapy such as tricyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines further stipulate that no commercially approved topical formulations of lidocaine cream, lotion, or gel are indicated for neuropathic pain. Thus, these guidelines do not support the use of topical lidocaine preparations which are not in patch form. As such, the currently requested topical formulation which contains lidocaine is not medically necessary.