

<b>Case Number:</b>	CM15-0027073		
<b>Date Assigned:</b>	03/20/2015	<b>Date of Injury:</b>	04/23/2013
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2015

### 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: Preventive Medicine, Occupational Medicine

### 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 was a 66 year old female, who sustained an industrial injury on April 23, 2013. The injured worker previously received the following treatments surgery of the left distal radius, flurbiprofen 25% 15grams, Ultraderm base 45 grams and home therapy. The injured worker was diagnosed with fracture of left distal radius, which was angulated, persistent pain limited function of the left hand. According to progress note of December 16, 2014, the injured workers chief complaint was left wrist pain. The injured worker was wearing a brace and continued to use nonsteroidal cream. The injured worker complained of occasional sharp pain at the distal left ulna. The physical exam noted a well healed incision of the left distal ulna, There was no radial-ulnar articular instability. There was notable discomfort on the radial and ulnar deviation with both passive and active range of motion. Discomfort at the proximal carpal row and radial-ulnar joint. There was limited range of motion noted. The treatment plan included medication refills for flurbiprofen 25% 15grams, Ultraderm base 45 grams (Flurbiprofen 25%/Lidocaine 5% and Lipoderm Base) from date of service December 16, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flurbiprofen 25%15 grams Ultraderm base 45 grams (Flurbiprofen 25%-Lidocaine 5% in Lipoderm base): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 111-112.

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The efficacy in clinical trials for non-steroidal anti-inflammatory agents (NSAIDs) has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. The compounded medication requested is not recommended by the MTUS; therefore, it is not medically necessary.