

Case Number:	CM14-0119459		
Date Assigned:	09/16/2014	Date of Injury:	09/06/2006
Decision Date:	11/12/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	07/28/2014

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 Illinois. 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 injured worker is a 58-year-old female who reported an injury on 09/06/2006. The mechanism of injury was not provided. The injured worker has diagnoses of cervical spine sprain/strain, bilateral shoulder rotator cuff syndrome, left wrist sprain/strain, lumbar sprain/strain, right knee internal derangement and right knee medial condyle fracture. Past medical treatment included surgery and medications. Diagnostic testing was not provided. The injured worker underwent left wrist surgery, the date of which was not provided and distal radius open reduction and internal fixation of the left wrist, the date of which was not provided. The injured worker complained of left wrist pain rated as an 8/10 on the pain rating scale on 05/19/2014. There was radiating pain down to the left first, second and third fingers. The pain was worsening because of repetitive hand and arm movements, and repetitive overhead reaching. The injured worker also complained of right knee pain rated 7/10 on the numerical pain rating scale. The pain worsened due to prolonged walking (20 minutes) and walking on uneven surfaces. The physical examination of the left wrist/hand noted the patient had tenderness to palpation over the dorsal aspect. The range of motion was limited and painful upon dorsiflexion, palmar flexion, radial deviation, and ulnar deviation. In addition, the range of motion was limited due to spasm upon ulnar deviation, and limited due to swelling upon palmar flexion, radial deviation, and ulnar deviation. The examination of the right knee revealed tenderness to palpation over the parapatellar region. The range of motion was limited and painful upon flexion and extension, and also limited due to spasm and swelling. Medications were not provided. The treatment plan is for a compound cream (flurbiprofen 20%/tramadol 20%, and Mediderm) 210 g and (gabapentin 10%/amitriptyline 10%/dextromethorphan 10%, and Mediderm base) 210 g. The rationale for the request was not submitted. The Request for Authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound Cream (Fluribiprofen 20%/Tramadol 20% in Mediderm) 210 gm and (Gabapentin 10%/Amitriptyline 10%/Dextromethorphan 10% in Mediderm Base) 210 gm:
Upheld

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

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

Decision rationale: The request for Compound Cream (Fluribiprofen 20%/Tramadol 20% in Mediderm) 210 gm and (Gabapentin 10%/Amitriptyline 10%/Dextromethorphan 10% in Mediderm Base) 210 gm is not medically necessary. The injured worker complained of left wrist pain rated as an 8/10 on the pain rating scale on 05/19/2014. The California (MTUS) Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy and safety. The guidelines also state that any compound product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines recommend the use of Lidocaine for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder and use with neuropathic pain is not recommended as there is no evidence to support use. Gabapentin is not recommended for topical application as there is no peer reviewed literature to support their use. There is lack of documentation the injured worker has been treated with first line therapy. There is no indication that the injured worker has a diagnosis of osteoarthritis or tendinitis to a joint amenable to topical treatment. The guidelines do not recommend the use of Lidocaine in cream form for topical application. As the guidelines note any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended, the medication would not be indicated. The request for refills would not be indicated as the efficacy of the medication should be assessed prior to providing additional medication. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication. Given the above, the request is not medically necessary.