

<b>Case Number:</b>	CM14-0164213		
<b>Date Assigned:</b>	10/09/2014	<b>Date of Injury:</b>	01/30/2013
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	10/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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 Pain Management and is licensed to practice in California. 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 50 year old female with a date of injury on 1/30/2013. She has history of (a) right wrist sprain, rule out internal derangement; and (b) status post right knee arthroscopy with persistent pain. Previous treatments include x-rays, physical therapy, pain medication, magnetic resonance imaging (MRI) of the right knee, and braces. Operative notes dated August 8, 2013 indicates that the injured worker underwent diagnostic arthroscopy on the right knee with plica resection medial side, chondroplasty of the patella, and lateral partial meniscectomy. On September 4, 2013 she underwent bilateral lower extremity duplex venous ultrasound which revealed unremarkable results. Most recent records dated August 22, 2014 indicate that the injured worker presented complaints of experiencing occasional pain in the right wrist/hand. Pain was associated with numbness and tingling sensation as well as swelling of the hand and fingers. Pain was increased with repetitive flexion, grasping, gripping, pushing, pulling, and when opening jars and bottles. She also complained of loss of grip strength. Physical examination of the right knee noted medial and lateral joint line tenderness. Crepitus was also noted over the patellofemoral joint. There is decreased range of motion of the right wrist with tenderness over the scapholunate interval as well as triangular fibrocartilage complex. X-rays of the right knee showed good preservation of the joint space medially and laterally. Patellofemoral joint space was also well-preserved. There is no fracture. X-ray of the right wrist show no evidence of arthritic changes. There is no evidence of subluxation or dislocation. There is evidence of ulnar negative variants.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for Flurbiprofen 20%/Tramadol 20%/ Mediderm base #1 on 8/7/14:**  
Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) indicates that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen is an anti-inflammatory medication and tramadol is an opioid. At this time, the only Food and Drug Administration (FDA)-approved topical non-steroidal anti-inflammatory drug (NSAID) is diclofenac. There is no support from the reference guideline regarding topical use of tramadol. Therefore, the retrospective request for flurbiprofen 20%/tramadol 20%/mediderm base #1 on August 7, 2014 is not medically necessary.

**Retrospective request for Gabapentin 10%/Amitriptyline 10%, Dextromethorphan 10%/ Mediderm base #1 on 8/7/14:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) indicates that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the gabapentin component is not recommended by the referenced guidelines as there is no supporting peer-reviewed literature that supports its topical use. Therefore, the retrospective request for gabapentin 10%/amitriptyline 10%/dextromethorphan 10%/mediderm base #1 on August 7, 2014 is not medically necessary.