

<b>Case Number:</b>	CM13-0027219		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	01/21/1998
<b>Decision Date:</b>	07/31/2014	<b>UR Denial Date:</b>	08/28/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/20/2013

### 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 40-year-old male with a reported date of injury on 01/21/1998. The injury reportedly occurred when the injured worker was struck by a falling coworker. His diagnoses were noted to include status post left wrist scapholunate ligament tear with reconstruction, status post hardware removal of left wrist, status post left wrist fusion, and left wrist complex regional pain syndrome. His previous treatments were noted to include physical therapy, a home exercise program, rest, oral medications, chiropractic treatment, a stellate ganglion block, a spinal cord stimulator trial, and surgeries. The progress note dated 02/15/2014 reported the injured worker complained of left wrist/forearm pain. The physical examination revealed no clubbing, cyanosis, or edema to the extremities. The physical examination of the spine revealed no tenderness or decreased range of motion. The progress note dated 05/13/2014 revealed the injured worker reported no changes in his physical symptoms and that he was to be given an injection to his left shoulder and was very pessimistic about returning to work. The examination revealed he had a significant level of anxiety and depression. The Request for Authorization Form was not submitted within the medical records. The request is for fentanyl patch 50 mcg #15 and ketoprofen 20% cream; however, the provider's rationale was not submitted within the medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fentanyl Patch 50MCG #15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids Page(s): 76-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal patch), Fentanyl, Opioids, On-going Management Page(s): 44,47,78.

**Decision rationale:** The request for fentanyl patch 50 mcg #15 is not medically necessary. The injured worker has been taking this medication since at least 06/2013. The California Chronic Pain Medical Treatment Guidelines do not recommend fentanyl as a first line therapy. Duragesic is a trade name of a fentanyl transdermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin. The FDA approved product labeling states Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. The guidelines also state fentanyl is an opioid analgesic with a potency 80 times that of morphine. Weaker opioids are less likely to produce adverse effects than stronger opioids, such as fentanyl. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported by detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors should, be addressed. There is a lack of documentation with evidence of a decreased pain on a numerical scale, improved functional status, and side effects, and the last urine drug screen was performed 03/06/2014, which was positive for hydrocodone which was not prescribed by the physician. Therefore, due to the lack of evidence regarding significant pain relief, increased function, side effects, and with the urine drug screen revealing the use of hydrocodone, the ongoing use of opioid medications is not supported by the guidelines. Additionally, the request failed to provide the frequency at which the medication is to be utilized. As such, the requested service is not medically necessary.

**Ketoprofen 20% CREAM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

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

**Decision rationale:** The request for ketoprofen 20% cream is not medically necessary. The injured worker has been taking this medication since at least 06/2013. The California Chronic Pain Medical Treatment Guidelines primarily recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The efficacy in clinical trials for topical 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 guidelines' indications for topical NSAIDs are osteoarthritis and tendinitis, in particular that of the knee or elbow and other joints that are amenable to topical treatment, and are recommended for short term use (4 weeks to 12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. The guidelines state ketoprofen is a non FDA approved agent for topical application. It has an extremely high incidence of photocontact dermatitis. Therefore, the guidelines do not recommend the utilization of ketoprofen, and the guidelines state that any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines state the efficacy appears to diminish over time and, therefore, ketoprofen is not warranted. Additionally, the request failed to provide the frequency at which this medication was to be utilized. Therefore, the request is not medically necessary.