

Case Number:	CM14-0116438		
Date Assigned:	08/04/2014	Date of Injury:	04/10/2010
Decision Date:	09/22/2014	UR Denial Date:	07/24/2014
Priority:	Standard	Application Received:	07/24/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 who reported an injury on 04/10/2010. The mechanism of injury was cumulative trauma. The injured worker underwent an x-ray, MRI, and EMG. The injured worker's diagnoses included carpal tunnel syndrome, lesion of the ulnar nerve, sprain/strain unspecified site of the elbow and forearm, and wrist sprain/strain. The surgical history and prior therapies were not provided. The documentation of 07/02/2014 revealed the injured worker had pain, stiffness, weakness, and numbness in the lumbar spine and the left wrist. The office note was handwritten and difficult to read. The treatment plan included Naprosyn cream. The injured worker's pain with the medication was 4/10 to 5/10, and without 8/10 to 10/10. The documentation indicated the injured worker's left wrist continued to improve. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naprosyn cream 15% 240mg: 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, Topical NSAIDS Page(s): 111, 111-112.

Decision rationale: The California MTUS guidelines indicates that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines also indicate that 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. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). The clinical documentation failed to indicate the injured worker had a trial and failure of antidepressants and anticonvulsants. The duration of use could not be established. The documentation indicated the injured worker's pain with the medication was 4/10 to 5/10, and without 8/10 to 10/10. There was, however, a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Naprosyn cream 15% 240mg is not medically necessary.