

<b>Case Number:</b>	CM15-0133203		
<b>Date Assigned:</b>	07/21/2015	<b>Date of Injury:</b>	03/19/2013
<b>Decision Date:</b>	08/17/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2015

### 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 is a 36 year old female with an industrial injury dated 03/19/2013. The injured worker's diagnoses include wrist arthralgia, hand arthralgia and possible complex regional pain syndrome (CRPS) right hand and arm. Treatment consisted of diagnostic studies, prescribed medications, 16 sessions of physical therapy, 1 session of post-operative therapy, caudal steroid injections to the right wrist, wrist brace and periodic follow up visits. In a progress note dated 05/11/2015, the injured worker reported right shoulder pain with numbness and radiation down to the right wrist. The injured worker rated pain an 8/10. Objective findings revealed decreased range of motion throughout the wrist and hand, diffuse tenderness in the right upper extremity from elbow down to hand, limited range of metacarpophalangeal (MCP) and interphalangeal (IP) joints of the hand and decreased right wrist flexion and right hand grip. Treatment plan consisted of right ulnar release surgery and medication management. The treating physician prescribed Norco 10/325mg #60 and CM3 Ketoprofen 20% QTY: 1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80, 94-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

**Decision rationale:** MTUS Guidelines have very specific criteria to justify the long term use of opioid medications. These criteria include detailed documentation of pain relief from the opioids, length of pain relief from the opioids and functional improvements as a result of opioid use. These Guideline criteria are not met. There is no reasonable evidence of effective pain relief and no functional improvements are noted. There are no unusual circumstances to justify an exception to Guidelines. The Norco 10/325 mg #60 is not supported by Guidelines and is not medically necessary.

**CM3 Ketoprofen 20% QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs/Analgesics Page(s): 111-113.

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

**Decision rationale:** The MTUS Guidelines are very specific in stating that only FDA/Guideline approved topical agents are recommended and any compound including a non-recommended agent is not supported. The Guidelines specifically state that topical Ketoprofen is not supported due to the high incidence of photosensitivity. There are Guideline recommended alternatives. There are no unusual circumstances to justify an exception to Guidelines. Under these circumstances, the CM3 Ketoprofen 20% QTY: 1 is not supported by Guidelines and is not medically necessary.