

<b>Case Number:</b>	CM14-0125816		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	02/23/2006
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	07/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2014

### 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, has a subspecialty in Interventional Spine 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 patient is a 50 year old male with date of injury 2/23/06. The treating physician report dated 6/30/14 indicates that the patient presents with pain affecting the neck, back, left knee, left jaw, left arm, stomach and radicular pain into the left arm with depression and anxiety. The physical examination findings reveal decreased ranges of motion, decreased reflexes of left triceps and forearm, decreased grip strength on the left and antalgic gait. The current diagnoses are cervical discogenic syndrome, lumbar discogenic syndrome, reflex sympathetic dystrophy, knee pain, shoulder pain, depression, constipation, temporomandibular joint pain, right ankle pain and hypertension. The utilization review report dated 7/23/14 denied the request for Naprosyn 15% transdermal compound cream #30 #120 gm based on the MTUS guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Naprosyn 15% Transdermal Compound Cream #30 #120GM:** Upheld

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

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

**Decision rationale:** The patient presents with chronic pain affecting multiple body parts including the lumbar spine and shoulder. The current request is for Naprosyn 15% Transdermal Compound Cream #30 #120GM. The treating physician report dated 6/30/14 states, "He needs the topical cream for the localized pain in the shoulder and in the low back." The MTUS guidelines do not support the usage of topical NSAIDS for the treatment of spine, hip, shoulder or neuropathic pain. NSAID topical analgesics are indicated for osteoarthritis and tendinitis of the knee and elbow or other joints that are amenable to topical treatment. This treating physician specifically states that the prescribed cream is for the shoulder and low back for which topical NSAID is not indicated. Therefore the request is not medically necessary.