

<b>Case Number:</b>	CM14-0218516		
<b>Date Assigned:</b>	01/08/2015	<b>Date of Injury:</b>	09/04/2007
<b>Decision Date:</b>	03/10/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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. 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, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 44 year old female with a reported date of injury of September 4, 2007. The mechanism of injury is unknown. The current diagnoses include right wrist internal derangement, left cubital tunnel syndrome and left 5th digit trigger digit. On March 24, 2011, the injured worker underwent release of right posterior compartment for right De Quervain's tenosynovitis. The injured worker presented on 11/19/2014. Subjective complaints and objective findings were not provided on that date. The injured worker was instructed to initiate physical therapy 3 times per week for 4 weeks. A topical cream containing Naprosyn was issued. Additionally, the injured worker was instructed to continue interferential current stimulation. A Request for Authorization form was then submitted on 11/25/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 IF UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 117-121.

**Decision rationale:** California MTUS Guidelines state an interferential current stimulation unit is not recommended as an isolated intervention. There should be evidence that pain is ineffectively controlled due to diminished effectiveness of medications or side effects, a history of substance abuse, significant pain from postoperative conditions, or unresponsiveness to conservative measures. According to the documentation provided, there was no evidence of a failure to respond to appropriate conservative treatment. There is also no documentation of a successful 1 month trial with the interferential unit prior to the request for a unit purchase. There was no physical examination provided on the requesting date. As the medical necessity has not been established The request is not medically appropriate.

**1 PRESCRIPTION OF TOPICAL CREAM NAPROSYN 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 Page(s): 111-113.

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA approved topical NSAID is diclofenac. Therefore, the current request for a topical cream containing Naprosyn 240 mg is not medically appropriate. As such, the request is not medically necessary in this case.