

Case Number:	CM13-0020894		
Date Assigned:	11/01/2013	Date of Injury:	10/15/2004
Decision Date:	03/24/2014	UR Denial Date:	08/07/2013
Priority:	Standard	Application Received:	09/05/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 physician 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 72-year-old female who reported an injury on 10/15/2004 after she sustained a left arm injury while assisting repositioning of a student. The patient has an extensive treatment history to include medications, physical therapy, mobilization, injection therapy, and carpal tunnel release. The patient ultimately developed lower back pain as a result of her injuries and was treated with injection therapy, physical therapy, and medications. The patient also developed knee pain that was treated with injection therapy and medications and physical therapy. The patient's most recent clinical evaluation revealed that the patient had ongoing right knee pain that required the assistance of a cane for ambulation. The patient's medications were noted to be ketoprofen cream, Voltaren gel and Lyrica. The patient's diagnoses included osteoarthritis of the right knee, grade 4 ankle sprain, and low back pain. The patient's treatment plan included continuation of ketoprofen cream, Voltaren gel and Lyrica.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen Cream: 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 Page(s): 78.

Decision rationale: The requested ketoprofen cream is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the use of ketoprofen as a topical analgesic as it is not approved by the FDA in this formulation. Additionally, the patient's most recent clinical evaluation stated that the patient is no longer using the ketoprofen cream and has transitioned to an oral formulation. Therefore, the continued use of the medication is not indicated. As such, the requested ketoprofen cream is not medically necessary or appropriate.

Voltaren Gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 78.

Decision rationale: The requested Voltaren gel is not medically necessary or appropriate. Official Disability Guidelines do recommend the use of topical nonsteroidal anti-inflammatory drugs for osteoarthritis pain for short courses of treatment. The clinical document, however, indicates the patient is no longer using this medication as she considered it to be ineffective for pain control. Therefore, continued use would not be indicated. As such, the requested Voltaren gel as needed is not medically necessary or appropriate.

Dilaudid 1 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Dilaudid 1 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends continued use of opioids in the management of chronic pain be supported by quantitative pain assessment, managed side effects, evidence of increased functional capabilities, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review fails to provide evidence of pain relief, increased functional benefit, managed side effects, or that the patient is monitored for aberrant behavior. Additionally, the clinical documentation submitted for review does indicate that the patient has weaned herself off this medication and is no longer using it. Therefore, continued use would not be indicated. As such, the requested Dilaudid 1 mg is not medically necessary or appropriate.