

Case Number:	CM13-0053747		
Date Assigned:	06/09/2014	Date of Injury:	10/04/1999
Decision Date:	07/14/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	11/18/2013

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 Neuromuscular Medicine and is licensed to practice in Maryland. 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 57 year old male injured on 10/04/99 due to an undisclosed mechanism of injury. It is noted the injured worker was recently involved in a motor vehicle collision. Specific injuries sustained were not discussed in the documentation provided. Current diagnoses include lumbar disc disease with radiculitis, reactive depression, post-traumatic stress disorder, and post-burn injury. The clinical note dated 11/18/13 indicates the injured worker presented complaining of low back pain with radiation to the bilateral lower extremities, numbness and weakness in the right leg. The injured worker rated his pain at 7/10. The injured worker reports medications decrease the pain approximately 50% without side effects. The injured worker complained of abnormal sensations in his right lower extremity described as "worms crawling down his leg". Physical examination of the lumbar spine revealed decreased range of motion, positive straight leg raise on the right, tenderness in the lumbar spine, and decreased sensation to touch distal to the right knee. Treatment plan includes continuation of oral medications which include Duragesic patch, Norco, Dilaudid, Klonopin, and Valium. The initial request for 1 Ketoprofen 20% in UL 30 grams and 1 Ketoprofen 20% in UL 120 grams on 07/16/12 was initially non-certified on 11/12/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE KETOPROFEN 20% IN UL 30 GM AND ONE KETOPROFEN 20% IN UL 120 GM ON 07/16/2012: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Topical analgesics Page(s): 111.

Decision rationale: Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, the MTUS Guidelines and Food and Drug Administration (FDA), and Official Disability Guidelines (ODG) require that all components of a compounded topical medication be approved for transdermal use. Ketoprofen has not been approved for transdermal use. In addition, there was no discussion regarding the use of topical medications submitted for review. Therefore, Ketoprofen 20% in UL 30 gm and one Ketoprofen 20% in UL 120 gm on 07/16/2012 is not medically necessary and appropriate.