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| Case Number: | CM13-0055861 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 10/11/2011 |
| Decision Date: | 06/05/2014 | UR Denial Date: | 11/12/2013 |
| Priority: | Standard | Application Received: | 11/21/2013 |

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 Orthopedic Surgery 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 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 47 year old female injured on 10/11/11 as a result of repetitive injuries while performing normal work duties. The patient sustained injuries to her cervical spine, bilateral shoulders, bilateral arms/elbows, and bilateral wrists/hands/fingers. The patient underwent right carpal tunnel release on 01/17/13 with subsequent diagnoses of left wrist carpal tunnel syndrome and bilateral upper extremity pain. The documentation indicates the patient continues to complain of bilateral wrist and hand pain with associated numbness. She also reports shooting pain up into the left elbow area. Physical examination reveals cervical tenderness, bilateral wrist tenderness, and bilateral finger weakness. The patient has undergone surgical intervention, Cortisone injection, physical therapy, bracing, medication management, and activity modification.

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 Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

Decision rationale: As noted on page 111 of the 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. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CA MTUS requires that all components of a compounded topical medication be approved for transdermal use. Ketoprofen has not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, Ketoprofen cream cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.