

Case Number:	CM13-0068711		
Date Assigned:	01/03/2014	Date of Injury:	01/28/2004
Decision Date:	06/06/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/13/2013

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 Internal Medicine, 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 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 an injured worker with right upper extremity conditions including complex regional pain syndrome. Date of injury was January 28, 2004 Primary treating physician's progress report (PR-2) dated November 1, 2013 was provided by [REDACTED]. Subjective complaints: His main complaint today is severe right shoulder pain with very limited range of motion. He is also getting sharp, burning, aching, throbbing pains in the right arm down to the hand. The patient's pain score is 8/10 right now and averaged 6/10 over the preceding week. Objective Findings: Right Shoulder: Range of motion is extremely limited. The patient has pain with abduction and flexion and internal and external rotation. Diagnoses included complex Regional Pain Syndrome right upper extremity, right elbow surgery x2 ulnar nerve neurolysis, medial epicondylitis, right shoulder adhesive capsulitis, right shoulder rotator cuff tear, chronic pain syndrome, myofascial syndrome, neuropathic pain. Treatment plan included: Sintralyne, Clonidine, Fosamax, Pristiq, Arthrotec, Ketoflex Compounded Ointment transdermally, three times a day for inflammation, pain and muscle spasm over the right shoulder and upper arm area. Utilization review dated November 21, 2013 recommended non-certification of the request for Ketoflex compound ointment.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF KETOFLEX COMPOUND OINTMENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications; Topical NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 112.

Decision rationale: MTUS) Chronic Pain Medical Treatment Guidelines, Pages 111-112 state that topical analgesics are largely experimental in use. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is a non-FDA-approved agent. Ketoprofen is not currently FDA approved for a topical application. Ketoprofen has an extremely high incidence of photocontact dermatitis. Therefore, Ketoprofen is not recommended. Ketoprofen is the active ingredient in Ketoflex. Therefore, Ketoflex is not recommended. Therefore, the request for Ketoflex compound ointment is not medically necessary.