

Case Number:	CM14-0006109		
Date Assigned:	03/03/2014	Date of Injury:	05/12/2003
Decision Date:	06/30/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/13/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management 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 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 70-year-old male who has submitted a claim for shoulder pain, status post an assault with blunt trauma, resulting in left shoulder pain associated with an industrial injury date of 5/12/2003. The medical records from 2012- 2013 were reviewed, which revealed increased pain on his left shoulder graded 6/10. Activity was decreased because of pain. Medications were working well without side effects noted. The physical examination showed no limitation in flexion, extension, adduction, abduction, active and passive elevation, internal and external rotation of right shoulder. The Neer, Hawkins, Empty Can and Shoulder crossover tests were negative. No tenderness noted. The left shoulder had restricted movement at 140 degrees in abduction, because of pain. The Hawkins and Neer tests were positive. The Shoulder crossover test was negative. Tenderness was noted in the acromioclavicular joint and greater tubercle of the humerus. The left elbow has restricted range of motion. Pain was noted with the varus stress test. There was no laxity with varus/valgus stress test. Tenderness was noted over the olecranon process. The Tinel's sign was positive. There was pain to proximal forearm with the Yergason and Speed tests. The manual muscle test (MMT) was normal in both extremities. The treatment to date has included acupuncture sessions. The medications taken were Norco, Docusate Sodium, Voltaren Gel, Lidoderm patch and Ketoprofen gel. The utilization review from 12/17/13 denied the requests fro Ketoprofen gel 10% per request for authorization (RFA) 11/15/13 and Lidoderm patch per RFA 11/15/13. Ketoprofen gel was denied because it is not FDA approved for treatment of chronic pain. Regarding Lidoderm patch, it was denied because there was no documentation of neuropathic symptoms and no documentation of functional improvement associated with its use.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN GEL 10% (PER REQUEST FOR AUTHORIZATION 11/15/13) QTY: 3.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS (07/18/2009), TOPICAL ANALGESICS, PAGE 111-113.

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

Decision rationale: The Chronic Pain Guidelines indicate that Ketoprofen is not recommended by the Food and Drug Administration (FDA) for topical use, as there is a high incidence of photo contact dermatitis. The guidelines also indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. In this case, the patient's progress report dated 11/26/13 mentioned that Ketoprofen gel 10% works well to address acute inflammation and pain related to his daytime activities. It decreases his pain from 8/10 to 5/10. However, as stated in the guidelines, it is not FDA approved because of its adverse effect. There is no discussion in the documentation concerning the need for use of unsupported topical analgesic. Therefore, the request is not medically necessary.

LIDODERM 5% PATCH (PER REQUEST FOR AUTHORIZATION 11/15/13) #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM Page(s): 56-57.

Decision rationale: The Chronic Pain Guidelines indicate that Lidoderm is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). In this case, the patient's record dated 11/16/13 mentioned that Lidoderm patch helped him to tolerate his pain. However, the documents showed that his pain is not neuropathic in nature. Furthermore, the records did not document that he failed a trial of first-line therapy. The guidelines have not been met. Therefore, the request is not medically necessary.