

<b>Case Number:</b>	CM14-0111218		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	01/14/2013
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/16/2014

### 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 Medicine and is licensed to practice in Nevada and 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 injured worker is a 30 year old female injured on 01/14/13 as a result of repetitive motion resulting in right shoulder pain radiating from the neck distally into the right hand and thumb. Clinical note dated 06/09/14 indicated the injured worker presented complaining of right shoulder pain, stiffness, and weakness rated 5-7/10. The injured worker participated in physical therapy. Physical examination revealed decreased range of motion, rotator cuff exam 5/5 except for supraspinatus 4/5, negative belly press, negative uppercut, negative Yergason, AC and SC joint non-tender to palpation. Diagnosis included adhesive capsulitis of shoulder, and rotator cuff sprain strain. The injured worker received subacromial injection during office visit. Treatment plan included home exercise kit, formal physical therapy, magnetic resonance image of the right shoulder, discontinue ibuprofen, prescription for naproxen, Norco, Ketoprofen compounded cream. Initial request was non-certified on 06/16/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Ketoprofen topical compound cream - apply 3-4x daily 30g: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (updated 06/10/14) Compound drugs, Criteria for Compound drugs:

**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 topical medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for Ketoprofen has not been approved for transdermal use. It has an extremely high incidence of photocontact dermatitis and absorption of the drug depends on the base it is delivered in. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore Retrospective Ketoprofen topical compound cream - apply 3-4x daily 30g cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

**Retrospective Norco 10/325 1-2 tabs 3-4x daily #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids and Opioids, specific drug list Page(s).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 77.

**Decision rationale:** As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As such, Retrospective Norco 10/325 1-2 tabs 3-4x daily #60 cannot be recommended as medically necessary at this time.