

Case Number:	CM14-0114097		
Date Assigned:	08/04/2014	Date of Injury:	03/29/2007
Decision Date:	09/23/2014	UR Denial Date:	07/02/2014
Priority:	Standard	Application Received:	07/21/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain 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 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 male who reported an injury on 03/29/2007. The mechanism of injury was not provided within the medical records. No diagnosis was submitted for review. The injured worker reported tenderness to the entire left side of his body, and right shoulder complaints more than left shoulder described as throbbing and sometimes sharper pain involving the right shoulder. The injured worker reported the left shoulder was aching. The injured worker reported there was limitation of mobility in lifting and reaching activities. The injured worker described his lower back pain and pain in the hip area left more than right described as aching and sharper pain with sudden movements. The injured worker reported knee complaints greater on the right than left with buckling as well as reported complaints with weight bearing and loading activities. The injured worker reported he also had popping, cracking, and swelling in the knees. The injured worker reported his medications were Hydrocodone, Benicar, and Janumet. On physical examination, there was decreased range of motion with lower back pain and mobility. The injured worker's cervical spine examination was within normal limits. The injured worker's shoulder examination revealed shoulder pain with mobility on the right. Range of motion for the shoulders was decreased. Impingement testing elicited shoulder pain; however, no clinical instability was demonstrated. The hip examination revealed generalized complaints about the lower back and hip region; however, no crepitus or mobility of the hips and the range of motion of the hips were intact. The injured worker's knee examination revealed decreased range of motion and crepitus with mobility of the knees. There was diminished quadriceps tone as well. The injured worker had a positive patellofemoral inhibition sign to the right knee. The injured worker's prior treatments included diagnostic imaging and medication management. The injured worker's medication regimen included Hydrocodone, Benicar, and Janumet. The provider submitted request for retrospective request date of service 08/11/2010 for Ketoprofen

compound; however, the only clinical note provided was for 06/02/2011 and date of service retrospective for CapiDerm dated 07/01/2010. However, the only clinical note provided was dated 06/02/2011. A request for authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for pharmacy purchase for date of service 08/11/10 for Ketoprofen compound 120 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

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

Decision rationale: The request for 08/11/10 for Ketoprofen compound 120 ml is not medically necessary. The California MTUS Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. It was not indicated the injured worker had tried and failed antidepressants and anticonvulsants. In addition, Ketoprofen is not currently FDA approved for topical application. Per the guidelines, any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Furthermore, the provider did not indicate a rationale for the request. In addition, the request does not indicate a frequency or quantity for the Ketoprofen. Therefore, the request is not medically necessary.

Retrospective request for pharmacy purchase for date of service 07/01/10 for Capiderm Hot 120 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

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

Decision rationale: The request for date of service 07/01/10 for Capiderm Hot 120 ml is not medically necessary. It was not indicated the injured worker had tried and failed antidepressants or anticonvulsants. In addition, topical agents are largely experimental in use with few randomized controlled trials. Moreover, the provider did not indicate a rationale for the request. Furthermore, the request does not indicate a frequency or quantity. Therefore, the request is not medically necessary.

