MAXIMUS Federal Services

Case Number:	CM14-0115685		
Date Assigned:	08/04/2014	Date of Injury:	10/09/2009
Decision Date:	10/01/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/23/2014

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 and Rehabilitation, 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 36 year old male who reported a date of injury of 10/09/2009. The mechanism of injury was not indicated. The injured worker had diagnoses of right knee internal derangement and status post right hip arthroscopy, unsuccessful, with severe right hip pain and inability to ambulate without a cane. Prior treatments were not indicated within the medical records provided. Diagnostic studies included an MRI of the right hip on 01/21/2014 and an MR arthrogram of the right hip on 03/05/2014. Surgeries were not included within the medical records received. The injured worker had complaints of constant low back and right hip pain rated 10/10. The clinical note dated 03/25/2014 noted the injured worker had tenderness to palpation of the right hip. The clinical note dated 06/03/2014 noted the injured worker had pain in the right hip with flexion, abduction and internal rotation with pain radiating into the groin area. The injured worker's motor strength indicated weakness in the Iliopsoas muscle. Medications included topical analgesic creams. The treatment plan included the physician recommending a total right hip arthroplasty, Gabapentin, Flurbiprofen/Ketoprofen/Ketamine cream and a home health evaluation. The rationale was to provide an adjunctive treatment to allow a reduction in the total amount of oral medications needed and allowing an alternative when oral medications are not well tolerated for pain management of the injured worker. The request for authorization form was dated 03/25/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20%/Ketamine 10% Cream 120 GM: 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 Ketoprofen 20%/ Ketamine 10% cream 120 GM is not medically necessary. The injured worker had complaints of constant low back and right hip pain with the pain rated at 10/10 and, stated he was not attending physical therapy. The California MTUS guidelines indicate topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines note any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical NSAIDs, such as Ketoprofen, are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The guidelines note topical Ketamine is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. There is a lack of documentation indicating the injured worker has neuropathic pain and has failed antidepressants and anticonvulsants. There is a lack of documentation the injured worker has osteoarthritis or tendinitis to a joint amenable to topical treatment. Furthermore, the injured worker had complaints of pain in the low back and hip, the guidelines indicate topical analgesics are not proven effective for these areas but rather the knee, elbow or other amenable joints. Additionally, the request as submitted did not specify a frequency of use for the medication or a site to which the medication was to be applied. As such, the request is not medically necessary.