MAXIMUS Federal Services

Case Number:	CM14-0122426		
Date Assigned:	08/06/2014	Date of Injury:	01/01/2010
Decision Date:	09/11/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/04/2014

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 and Pain Management and is licensed to practice in Florida. 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 59-year-old female who reported an injury on 01/01/2010 due to an unknown mechanism. Diagnoses were history of left total knee arthroplasty with persistent pain. Metal allergy left knee, status post revision left knee arthroplasty with resultant RSD (reflex sympathetic dystrophy syndrome) in the anterior soft tissues of the knee. Chronic pain syndrome left leg of unknown etiology, possible RSD. Right greater trochanteric bursitis as a compensable consequence due to gait abnormalities secondary to chronic pain left lower extremity. Status post left shoulder arthroscopy, debridement of partial thickness rotator cuff tear and early evidence of chondromalacia of the glenohumeral space. Past treatment reported was physical therapy. Diagnostic studies were x-rays of the left knee. Past surgical history was left total knee arthroplasty, left shoulder arthroscopy and manipulation under anesthesia with injection of local anesthesia, left kneecap. Physical examination on 07/17/2014 revealed complaints of pain in the left knee and hip. Examination of the left knee revealed mild swelling. There was hypersensitivity to light touch on the anterior medial aspect of the knee on the skin, across the whole top of the knee. There was an area of numbness to light touch. Range of motion for flexion was to 95 to 100 degrees and extension was 0. Medications that were reported were ketoprofen 10%, lidocaine 5% cream. Treatment plan was to continue with physical therapy and medications as directed. The rationale and Request for Authorization form were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound: Ketoprofen 10%; Lidocaine 5% Cream 120mg with 2 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Topical Analgesicsnon-steroidal anti-inflammatory drug (NSAIDS).

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

Decision rationale: The request for compound ketoprofen 10%, lidocaine 5% cream 120 mg with 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Ketoprofen is not currently FDA approved for a topical application. The guidelines do not recommend ketoprofen and, as such, the use of the compound would not be supported. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED, such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines do not support the medical necessity for compounded medications. Therefore, the request is not medically necessary.