

Case Number:	CM14-0184216		
Date Assigned:	11/12/2014	Date of Injury:	06/20/2014
Decision Date:	12/30/2014	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/05/2014

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 Pain Management and Rehabilitation, has a subspecialty in Interventional Spine 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 54 year old female with an injury date of 06/20/14. Based on the 11/07/14 progress report provided by treating physician, the patient complains of pain to neck, back, left knee, right leg and left foot rated 8-9/10. Patient also reports frequent occipital to frontal headaches rated 3-8/10. EMG/NCV of the upper extremities 10/13/14 revealed NCV was within normal limits and EMG revealed chronic left L5 radiculopathy (weakness is on her right lower extremity). Patient has had seven sessions of physical therapy to the cervical spine, lumbar spine and right knee with no help. Patient is temporarily totally disabled. Diagnosis on 11/07/14 included the following:- musculoskeletal headaches- cervical spine sprain/strain- lumbar spine sprain/strain- bilateral hip pain- bilateral knee sprain- left foot sprain- rule out phlebitis of right lower extremity- history of rheumatoid arthritis- history of foot drop The utilization review determination being challenged is dated 10/31/14. Treatment reports were provided from 05/29/14 - 11/07/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 100% #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesic Page(s): 111-113.

Decision rationale: The patient presents with pain to neck, back, left knee, right leg and left foot rated 8-9/10. The request is for Ketoprofen 100% #240. Patient also reports frequent occipital to frontal headaches rated 3-8/10. EMG/NCV of the upper extremities 10/13/14 revealed NCV was within normal limits and EMG revealed chronic left L5 radiculopathy (weakness is on her right lower extremity). Patient has had seven sessions of physical therapy to the cervical spine, lumbar spine and right knee with no help. Patient is temporarily totally disabled. "Topical Analgesics: Non-steroidal ant inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." Treater has not stated reason for the request, nor what body part will be treated. The request is not mentioned in provided medical reports. Per UR letter dated 10/31/14, the request refers to Ketoprofen 100% Microsome base cream. Per UR letter dated 08/25/14, the request refers to Cyclobenzaprine/Ketoprofen/Lidocaine cream 240mg #1. With regards to NSAID cream, review of reports do not show documentation that patient presents with osteoarthritis, as indicated by guidelines. Furthermore, intended use is 2 week period due to diminishing effect. The request for Ketoprofen 100% #240 is not medically necessary.