

Case Number:	CM14-0023971		
Date Assigned:	06/11/2014	Date of Injury:	03/04/2010
Decision Date:	07/15/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	02/25/2014

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 66-year-old female who reported an injury on 03/04/2010. The mechanism of injury was not provided within the medical records. The clinical note dated 06/09/2014 indicated diagnoses of contusion to the left elbow, left elbow tendonitis, shoulder, wrist, status post arthroscopic surgery, contusion to bilateral knees, medial meniscal tear, left knee status post-surgery, wrist arthropathy, left wrist tendonitis, right hip and lower back sprain due to fall on 03/23/2013, right hip labral tear, and left shoulder injury. The injured worker reported left shoulder and wrist pain as well as bilateral knee pain. The injured worker reported lumbar radicular pain that radiated to left knee and both legs. She also reported tingling sensation. The injured worker reported back spasms when she sat for 15 to 20 minutes. The injured worker reported weakness in the left arm and hand and loss of strength. On physical exam, there was tenderness with palpation of right trochanteric bursa and right trapezius muscle spasms. The injured worker's right medial knee was tender to touch. The injured worker had pain to the right hip that was worsened with abduction and adduction and there was tenderness to palpation of the right hip. There was tenderness to palpation to the left knee medial joint line. The injured worker had a positive click to the left knee with her walk. The injured worker's left knee was swollen at the medial and anterior and there was slight tenderness at the medial tibial plateau and joint line. There was tenderness with lateral rotation of the left knee. The injured worker was unable to move the left shoulder beyond 100 degrees abduction. Flexion was 110 degrees. The injured worker had a click when she rotated her arm. The injured worker had tenderness to her right hip and lower back, bilateral tenderness and spasms of the L3-5 paraspinous muscles. An examination of the lumbar spine revealed decreased range of motion, extension was 5 degrees, flexion was 45 degrees, bilateral lateral bending was 10 degrees and rotation was 15 degrees. There was pain with extension of the back localizing to the lumbar facet

joints. The injured worker had persistent pain with palpation of the right hip and range of motion was decreased in abduction by 10 degrees. The injured worker's prior treatments included diagnostic imaging, surgery, and medication management. The injured worker's medication regimen included Anaprox, Prilosec, Neurontin, Norco, Valium, Theramine, Sentra PM, Trepidone, and Sentra AM. The provider submitted a request for Ketoprofen cream and urine drug screen. 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:

KETOPROFEN CREAM QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111-113.

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

Decision rationale: The request for ketoprofen cream quantity 1 is non-certified. The California Chronic Pain Medical Treatment Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficiency or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines also state Ketoprofen is not currently FDA approved for a topical application. Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. The guidelines state ketoprofen is not currently FDA approved for topical application. The guidelines further state any compounded product that contains at least one drug or drug class that is not recommended is not recommended. In addition, the request did not provide a frequency or dosage for the medication. Therefore, the ketoprofen cream quantity 1 is not medically necessary.

URINE DRUG SCREEN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Screening Section Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Screening Section Page(s): 43.

Decision rationale: The request for urine drug screen is non-certified. The California Chronic Pain Medical Treatment Guidelines recommend a urine drug test as an option to assess for the use or the presence of illegal drugs. It may also be used in conjunction with a therapeutic trial of Opioids, for on-going management, and as a screening for risk of misuse and addiction. Although the injured worker is on opiates the documentation submitted did not indicate the injured worker had findings that would support she was at risk for misuse or addiction. Therefore, the request for urine drug screen is not medically necessary.