

Case Number:	CM14-0025982		
Date Assigned:	06/13/2014	Date of Injury:	02/24/2012
Decision Date:	07/16/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	02/28/2014

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 Texas. 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 52 year old male with a reported injury on 02/24/2012. The mechanism of injury was not provided. The injured worker had an exam on 10/02/2013 at which he complained of right shoulder and lower back pain and decreased motion. The injured worker has been participating in a home exercise program and taking his medications. He had injections with no response. He had physical therapy and acupuncture. There was no documentation provided for the medication list and the physical therapy assessments. The injured worker complained of erectile dysfunction and sleep disturbances due to the pain. The injured worker had a positive straight leg test bilaterally and his right shoulder range of motion was limited in all directions. His forward flexion was at 135 degrees, external rotation was at 35 degrees and abduction was at 80 degrees. His urinalysis on 07/17/2013 was consistent with his medications. He did provide a pain assessment and activity of daily living assessment on 07/09/2013, which is in Spanish. His diagnoses are right shoulder adhesive capsulitis with possible intra-articular injury/or partial thickness rotator cuff tear, lumbosacral strain/arthrosis/discopathy with radiculopathy. The plan of treatment is Ketoprofen gel, Theramine, and twelve weeks of physical therapy for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR MEDICATIONS KETOPROFEN GEL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Non-steroidal anti-inflammatory agents (NSAIDs).

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

Decision rationale: The injured worker has right shoulder and lower back pain with decreased range of motion. The California MTUS guidelines state that the efficacy of non-steroidal anti-inflammatory agents topically has been inconsistent. There is no long-term study on the effectiveness and safety of this medication. The California MTUS guidelines state that topical non-steroidal anti-inflammatory agents have not been evaluated for use on the spine, hip or shoulder. The guidelines also state that Ketoprofen is not FDA approved for topical use. The request did not provide duration, dose and frequency and location to place the gel. Therefore, the request for Ketoprofen gel is not medically necessary.