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| Case Number: | CM14-0030767 | | |
| Date Assigned: | 04/09/2014 | Date of Injury: | 10/11/2011 |
| Decision Date: | 05/27/2014 | UR Denial Date: | 01/15/2014 |
| Priority: | Standard | Application Received: | 01/24/2014 |

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 and is licensed to practice in Illinois. 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 55-year-old male who reported an injury on 10/11/2011 after he delivered a refrigerator which caused a sudden onset of low back pain. The injured worker's treatment history included physical therapy, acupuncture, epidural steroid injections, and multiple medications. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 12/20/2013. It was documented that the injured worker had pain rated at an 8/10. Physical findings included a positive bilateral straight leg raising test, motor strength weakness in the extensor hallucis longus and tibialis anterior muscle groups rated at a 4/5 bilaterally with decreased sensation in the posterior aspect of the calf. The injured worker's diagnoses included a grade 1 spondylolisthesis at the L5-S1, cervical spine musculoligamentous sprain/strain, and right L4-5 and bilateral L5-S1 foraminal narrowing with disc bulging. At the time of evaluation, the injured worker's treatment plan included acupuncture, a urine drug screen and refill of medications to include topical analgesics.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN 20% / KETAMINE 10% GEL 120GM: Upheld

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

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

Decision rationale: The requested ketoprofen 20%/Ketamine 10% gel 120 gm is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of ketoprofen as a topical analgesic as it is not FDA approved to treat neuropathic pain. Additionally, Ketamine as a topical analgesic is only supported when all other first line chronic pain management treatments have failed to resolve the injured worker's pain. The clinical documentation submitted for review does not provide any evidence that the injured worker had failed to respond to first line treatments to include antidepressants and anticonvulsants. Therefore, the use of Ketamine as a topical analgesic is not supported. California Medical Treatment Utilization Schedule states that any medication that contains at least 1 drug or drug class that is not supported by guideline recommendations is not supported. As such, the requested Ketamine/ketoprofen is not medically necessary or appropriate.