

<b>Case Number:</b>	CM14-0033090		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	07/26/2006
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	03/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/15/2014

### 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 has a subspecialty in Pain Medicine and is licensed to practice in California and Nevada. 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 67 year old female injured on 07/26/06 due to an undisclosed mechanism of injury. Current diagnoses include cervical disc disorder with radiculitis, degeneration of lumbar disc, shoulder pain and depressive disorder. The clinical documentation indicates the injured worker presented on 01/22/14 complaining of neck and upper extremity pain with a history of right rotator cuff tear. The injured worker was recommended for right shoulder surgery; however, surgical intervention was placed on hold due to significant lung disease. Treatment with Prednisone 10mg per day was initiated. The injured worker also reported prior Gastroesophageal reflux disease (GERD) symptoms improved after initiation of Nexium. The injured worker reports complaints of neck pain rated at 7/10 with radiation down the bilateral upper extremities, left greater than right. The injured worker reports use of Motrin, Voltaren gel, and heat are ineffective for pain management. The documentation indicates the injured worker reports 3 prior trigger point injections without significant decrease in pain. Physical examination reveals non-antalgic gait, no assistive devices utilized, ability to sit for 15 minutes without any limitations or evidence of pain, and flat affect. Current medications include compound cream, Myfortic, Famotidine, Prednisone, Aspirin, Cyclobenzaprine and Ketoprofen. The initial request for Ketoprofen 75mg #120 with 0 refills and compounded cream 360 grams #3 with 0 refills was initially non-certified on 03/04/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketoprofen 75mg #120, zero refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects, Page(s): 70.

**Decision rationale:** Non-steroidal anti-inflammatory drugs (NSAIDs) are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Package inserts for NSAIDs recommend periodic lab monitoring of a complete blood count and chemistry profile (including liver and renal function tests). There is no documentation that these monitoring recommendations have been performed and the patient is being monitored on a routine basis. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. Further, there is no indication the patient cannot utilize a readily available over-the-counter formulation of non-steroidal anti-inflammatory drug. As such, the request for Ketoprofen 75mg #120, zero refills cannot be established as medically necessary.

**Compound Cream 360gm #3 zero refills:** Upheld

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

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

**Decision rationale:** Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, California Medical Treatment Utilization Drugs, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. The request did not specify the components allowing for determination of United States Federal Drug Administration approval status. Therefore the request for Compound Cream 360gm #3 zero refills cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.