

Case Number:	CM13-0037161		
Date Assigned:	12/13/2013	Date of Injury:	01/10/2008
Decision Date:	04/24/2015	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/23/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

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 58-year-old male, who sustained an industrial injury on 01/10/2008. Initial complaints reported included pain and injury to the bilateral shoulders and upper extremities (elbows/wrist), headaches, and cervical, thoracic and lumbar spines due to cumulative trauma. The initial diagnoses were not provided. Treatment to date has included conservative care, medications, x-rays, electrodiagnostic testing of the bilateral upper and lower extremities, MR arthrogram of the bilateral shoulders, injections, left shoulder surgery, physical therapy, injections to the cervical spine, right shoulder and low back, right shoulder surgery, chiropractic manipulation, psychotherapy, and physical therapy. At the time of the request for authorization, the injured worker complained of ongoing bilateral shoulder pain and low back pain. Diagnoses include bilateral shoulder impingement syndrome, insomnia, lumbar radiculopathy, and gastropathy secondary to anti-inflammatory medication. The treatment plan consisted of continued oral medications, Ketoprofen spray, and follow-up.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN SPRAY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: Ketoprofen Spray is not medically necessary. According to California MTUS, 2009, chronic pain, page 111 California MTUS guidelines does not cover "topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended, is not recommended." Additionally, Per CA MTUS page 111 states that topical analgesics such as Ketoprofen, is indicated for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. It is also recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of pain associated with the spine, hip or shoulder; therefore, compounded topical cream is not medically necessary.