

<b>Case Number:</b>	CM15-0147954		
<b>Date Assigned:</b>	07/31/2015	<b>Date of Injury:</b>	08/16/2009
<b>Decision Date:</b>	08/27/2015	<b>UR Denial Date:</b>	06/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

### 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 female who sustained an industrial injury on 08/16/09. She reported knee pain. Initial diagnoses are not available. Current diagnostic impression is reported as degenerative arthritis both knees bilateral. Diagnostic testing and treatment to date has included radiographic imaging, physical therapy, and pain management. Currently, the injured worker complains of constant pain in both knees with numbness in both legs and feet; she has total body pain. Requested treatments include lidocaine 10%/Ketoprofen 10% cream, Voltaren 1% 40g tube, and Zofran 4mg #30. The injured worker is under temporary total disability. Date of Utilization Review: 06/17/15.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidocaine 10%/Ketoprofen 10% cream:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** Lidocaine 10%/Ketoprofen 10% cream is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that topical NSAIDs are indicated in osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The guidelines indicate that topical formulations of lidocaine (whether creams, lotions or gels) are not indicated for neuropathic pain. Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. The documentation does not indicate intolerance to oral medications. The guidelines additionally add that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical Lidocaine and topical Ketoprofen are not recommended by the MTUS therefore, the request for Lidocaine/Ketoprofen cream is not medically necessary.

**Voltaren 1% 40g tube:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** Voltaren 1% 40g tube is not medically necessary per the MTUS Guidelines. The MTUS states that topical Voltaren is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. The MTUS recommends topical NSAIDs for short-term use. The MTUS states that topical analgesics are largely experimental and used primarily for neuropathic pain when antidepressants and anticonvulsants have failed. The documentation does not indicate failure of oral medications and therefore this request is not medically necessary.

**Zofran 4mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain-Antiemetics (for opioid nausea).

**Decision rationale:** Zofran 4mg #30 is not medically necessary per the ODG. The MTUS does not address this request. Zofran is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis. The documentation does not indicate that the patient meets the indications for Zofran use therefore this request is not medically necessary.

