

Case Number:	CM15-0068460		
Date Assigned:	05/14/2015	Date of Injury:	07/09/2001
Decision Date:	07/09/2015	UR Denial Date:	03/23/2015
Priority:	Standard	Application Received:	04/10/2015

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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational 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 50 year old male who sustained an industrial injury on 07/09/2001. The injured worker was diagnosed with arthrofibrosis left knee, lumbar sprain/strain with facet overgrowth, degenerative disc disease, disk herniation at L4-L5 and lumbar radiculopathy. The injured worker has a medical history of hypertension, diabetes mellitus and hyperlipidemia. The injured worker is status post left total knee replacement with complication of arthrofibrosis, manipulation under anesthesia of the left knee and eye surgery for pterygium. The dates of surgical interventions were not documented. Treatment to date includes diagnostic testing, surgery, physical therapy, epidural steroid injection and medications. According to the primary treating physician's progress report on March 5, 2015, the injured worker continues to experience worsening back pain with severe spasm radiating to both legs and right knee pain. The injured worker rates his pain level at best 4/10 with medications and 10/10 without medications. Examination of the left knee demonstrated a very swollen knee with active flexion of 90 degrees, extension at 5 degrees with crepitus on both maneuvers. No gross laxity with stress testing was noted. The lower back examination revealed limited range of motion with positive straight leg raise bilaterally. There is sensory loss at the right lateral calf and bottom of his foot and he ambulated with a limp. Deep tendon reflexes were +1 at the knees, +1 at the left Achilles and an absent right Achilles. There was weakness in right thigh flexion, knee extension and great toe extension. Current medications are listed as Avinza 90mg daily, Norco10/325 for breakthrough pain upper to 6 per on day, Mobic, Lidoderm Patch, Ambien, and Nexium. Treatment plan consists of ophthalmology re-evaluation, updated cervical, thoracic and lumbar magnetic resonance imaging (MRI), referral for epidural steroid injection, orthopedic

consultation and the current request for Ketoprofen 10% Cyclo 3% Capsaicin 0.0375% Menthol 2% Camphor 1% IN UL 30gm #1 x 2 refills DOS 2/15/15; Ketoprofen 10%/Cyclo 3%/Capsaicin 0.0375%/menthol 2%/Camphor 1% IN UL 120gm with 2 refills; Ketoprofen 20% IN UL 30gm with 2 refills; Ketoprofen 20% IN UL 120gm #1 x 2 refills DOS 2/15/15 and tube DOS 2/15/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 10% Cyclo 3% Capsaicin 0.0375% Menthol 2% Camphor 1% IN UL 30gm #1 x 2 refills DOS 2/15/15: 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): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: MTUS and ODG recommends usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended. Per ODG and MTUS, Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis and photosensitization reactions. Therefore, the request is not medically necessary.

Ketoprofen 20% IN UL 120gm #1 x 2 refills DOS 2/15/15: 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): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

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Tube, DOS 2/15/15: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: MTUS and ODG recommends usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended. The request does not specify any of the drugs that are contained in it. Therefore, the request is not medically necessary.