

Case Number:	CM14-0182787		
Date Assigned:	11/07/2014	Date of Injury:	08/27/1997
Decision Date:	12/11/2014	UR Denial Date:	10/24/2014
Priority:	Standard	Application Received:	11/03/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 56-year-old woman who sustained a work-related injury on August 27, 1997. Subsequently, she developed with chronic bilateral hand pain and upper extremities pain. According to a progress report dated on September 26, 2014, the injured worker continued to have stabbing pain in both upper extremities the including the shoulders and hands wrist and elbows. Physical examination demonstrated the tenderness to both upper extremities with reduced range of motion of right shoulder, positive rotator cuff impingement sign with decreased stance in both upper extremities, decreased range of motion of the wrist bilaterally and weakness on thumb flexion and extension. The provider is requesting authorization for the use topical analgesic.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 10%, Tramadol 10% Cream 180gm: Upheld

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

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

Decision rationale: Per MTUS Chronic Pain Medical Treatment guidelines, section Topical Analgesics; topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no evidence that Ketoprofen gel is recommended as topical analgesics for chronic pain. Ketoprofen gel, a topical analgesic is not recommended by MTUS guidelines. Furthermore, Ketoprofen was reported to have frequent photocontact dermatitis. There is no documentation of failure of Motrin or first line pain medications. Based on the above Ketoprofen 10%, Tramadol 10% cream 180gm is not medically necessary.