

Case Number:	CM14-0097639		
Date Assigned:	07/23/2014	Date of Injury:	01/22/2011
Decision Date:	09/19/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/14/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Ohio. 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 54 year old male with a reported date of injury on 01/22/2011. The mechanism of injury was not provided. The injured worker's diagnoses included sprain of shoulder/arm. Past treatment included medication and physical therapy. No diagnostic testing/results was provided. The injured worker has had a left shoulder arthroscopy (unofficial, date unknown) as per a note dated 05/07/2014. On a clinic note dated 01/29/2014, which was mostly illegible, the injured worker complained of left shoulder pain at a level of 7/10. The clinician indicated the injured worker had decreased range of motion to left shoulder, but did not quantify range of motion values. On 02/17/2014, side illegible; shoulder pain of 2-7/10 was reported which increased with repetitive use. The clinician listed reflexes as +2. On 04/09/2014, the clinician reported a toxicology report consistent with hydrocodone prescription and physical therapy helped with range of motion and strength but also reported weakness without quantifying the range of motion values. On 05/07/2014 the injured worker reported constant left shoulder pain of 2-8/10. The medication history included hydrocodone/acetaminophen 10/325 mg, tramadol ER HCL 150 mg, zolpidem tartrate 10 mg, diazepam 10 mg (frequencies not provided), gabapentin/acety-l-carnitine 550/75mg 1-4 times daily as needed, Biofreeze topical, and Duexis 80/26.6 mg QAM. Ketoprofen compound cream was requested. Additionally, no rationale and authorization form was provided for this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen Compound Cream: 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): 111-112.

Decision rationale: The injured worker sustained an injury on 01/22/2011 and has since been treated with medications and physical therapy. The California Chronic Pain Medical treatment Guidelines recommend topical NSAIDs for short term (4-12 weeks) use for osteoarthritis, and do not recommended topical NSAIDs for use on the shoulder. No documentation of osteoarthritis was provided and all clinical documentation that was provided pertaining to the shoulders. The submitted request does not indicate the strength of the requested medication, the site at which it is to be applied, or the frequency at which the medication is prescribed in order to determine the medical necessity of the medication. Therefore, the request for ketoprofen compound cream was not medically necessary.