

Case Number:	CM15-0017128		
Date Assigned:	02/03/2015	Date of Injury:	07/06/1999
Decision Date:	03/23/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/26/2015

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: California
Certification(s)/Specialty: Emergency 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 45 year old female, who sustained an industrial injury on July 6, 1999. The diagnoses have included lumbar spondylosis, degenerative disc disease of the lumbar spine, lumbar radiculopathy, chronic pain syndrome, annular tear, facet arthropathy with retrolisthesis and broad based bilge with central pronation at L5-S1, and moderate L4-L5 canal stenosis. Treatment to date has included spinal cord stimulator implantation on February 28, 2014, epidural steroid injection (ESI), physical therapy, acupuncture, chiropractic treatments, and medications. Currently, the injured worker complains of ongoing low back and neck pain with radicular symptoms in bilateral arms and legs, and three days of migraines which increased the neck symptoms, and difficulty sleeping. The Primary Treating Physician's report dated November 14, 2014, noted the injured worker with continuing significant tenderness to palpation of the lumbar spine with spasms into the right paraspinal region, and decreased range of motion (ROM) in the lumbar spine. The injured worker was noted to have decreased sensation in the right L4, L5, and S1 dermatomes and decreased strength in the right lower extremity secondary to pain. On December 23, 2014, Utilization Review non-certified CM3-Ketoprofen 20%. The UR Physician's determination rationale was not included in the documentation provided. MTUS Chronic Pain Medical Treatment Guidelines was cited. On January 26, 2015, the injured worker submitted an application for IMR for review of CM3-Ketoprofen 20%.

IMR ISSUES, DECISIONS AND RATIONALES

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

CM3-Ketoprofen 20%: 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 page 111-113, Topical Analgesics Page(s): 111-113.

Decision rationale: The requested CM3-Ketoprofen 20%, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has low back and neck pain with radicular symptoms in bilateral arms and legs, and three days of migraines which increased the neck symptoms, and difficulty sleeping. The Primary Treating Physician's report dated November 14, 2014, noted the injured worker with continuing significant tenderness to palpation of the lumbar spine with spasms into the right paraspinal region, and decreased range of motion (ROM) in the lumbar spine. The injured worker was noted to have decreased sensation in the right L4, L5, and S1 dermatomes and decreased strength in the right lower extremity secondary to pain. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, CM3-Ketoprofen 20% is not medically necessary.