

Case Number:	CM15-0113786		
Date Assigned:	06/22/2015	Date of Injury:	04/04/2014
Decision Date:	07/28/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	06/12/2015

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: Texas, California

Certification(s)/Specialty: Family Practice

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 20 year old male injured worker suffered an industrial injury on 04/04/2014. The diagnoses included herniated disc lumbar spine, mechanical back pain and facet arthropathy lumbar spine. The diagnostics included lumbar magnetic resonance imaging and electromyographic studies/nerve conduction velocity studies. The injured worker had been treated with physical therapy, chiropractic therapy and medications. On 4/8/2015 the treating provider reported continuous low back pain rated 6/10 with radiation into the bilateral groin. On exam the lumbar spine range of motion was limited with positive facet signs. The treatment plan included CM3 Ketoprofen 20%. The medication list include Tramadol, Ketoprofen cream and Biofreeze. Patient has received an unspecified number of PT visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

CM3-Ketoprofen 20% Rx #156161: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain - Topical Analgesics, pages 111-112 Topical Analgesics.

Decision rationale: Request: CM3-Ketoprofen 20% Rx #156161, According to the MTUS Chronic Pain Guidelines regarding topical analgesics state that the use of topical analgesics is "Largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. 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 is not recommended." MTUS guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. Any trial of antidepressants and anticonvulsants for these symptoms were not specified in the records provided. Any intolerance or contraindication to oral medications was not specified in the records provided. Ketoprofen is a NSAID. Per the cited guidelines, "Non-steroidal antiinflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration." The request for CM3-Ketoprofen 20% Rx #156161 is not medically necessary in this patient.