MAXIMUS Federal Services

Case Number:	CM15-0179974		
Date Assigned:	09/22/2015	Date of Injury:	10/09/2013
Decision Date:	10/30/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/14/2015

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, Hawaii
Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 44-year-old female, who sustained an industrial injury on 10-09-2013. The injured worker was diagnosed as having carpal tunnel syndrome- wrist sprain, cervical spine pain, cervical spine sprain-strain, cervical canal stenosis, thoracic spine pain, thoracic spine sprain-strain and lumbar spine sprain-strain. On medical records dated 07-28-2015, subjective complaints were noted as burning neck pain, right shoulder pain, mid back pain, low back pain, spasms, and left wrist pain. Objective findings were noted as cervical spine revealed tenderness to palpation at the paraspinal, trapezius and scalene muscles. Right shoulder revealed a decreased range of motion and tenderness at the deltopectoral groove and on the insertion of the supraspinatus muscle. Left wrist revealed mild swelling and a well-healed scar, tenderness to palpation was noted over the carpal bones and over the thenar and hypothenar eminence bilaterally and a decreased range of motion was noted as well. Thoracic spine revealed tenderness to palpation with spasms noted over the bilaterally thoracic paraspinal muscles. Lumbar spine revealed tenderness to palpation as well as spasms at the lumbar paraspinal muscles and over the lumbosacral junction. Trigger point were noted at the left quadratus. Lumbar spine was noted to have a decreased range of motion. Treatment to date included medication and therapy. Current medication was listed as Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine and Ketoprofen Cream. The injured worker was noted to be using Ketoprofen cream since at least 04-2015. The Utilization Review (UR) was dated 09-01-2015. A Request for Authorization was dated 07-28-20015. The UR submitted for this medical review indicated that the request for functional capacity evaluation and Ketoprofen 20% cream were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional capacity evaluations: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for duty - Functional capacity evaluation ACOEM Chapter 7 - Independent Medical Examinations and Consultations page 137-138.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, page 137.

Decision rationale: The patient presents with diagnoses that include status post left carpal tunnel release and previous left wrist fracture with wrist deformity, right wrist overuse with ganglion cyst. The patient currently complains residual pain that is constant and moderate along with weakness, numbness, tingling and pain that radiates to the hands and fingers. The current request is for Functional capacity evaluations. The treating physician states in the treating report dated 7/28/15 (328B), "The patient is referred for a Functional Capacity Evaluation (FCE)." MTUS Guidelines do not discuss functional capacity evaluations. ACOEM chapter 7, was not adopted into MTUS, but would be the next highest-ranked standard according to LC4610.5 (2) (B). ACOEM does not appear to support functional capacity evaluations unless the employer or claims administrator makes the request following the treating physician making work restriction recommendations. ACOEM states, "The examiner is responsible for determining whether the impairment results in functional limitations and to inform the examinee and the employer about the examinee's abilities and limitations. The physician should state whether the work restrictions are based on limited capacity, risk of harm, or subjective examinee tolerance for the activity in question. The employer or claim administrator may request functional ability evaluations, also known as functional capacity evaluations, to further assess current work capability." In this case, the treating physician has not documented any basis for the request. The clinical history does not document any unsuccessful return to work attempts. Additionally, the AME states in the 2/18/15 (60B) reevaluation report, "Work Status: The patient is a qualified injured worker (QIW) and medically eligible for vocational rehabilitation." There is no documentation found indicating that the employer or claims administrator was not challenging the physicians' lack of work restrictions, nor QIW status, and they did not request an FCE. Therefore, the current request is not medically necessary.

Ketoprofen 20% cream 167gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The patient presents with diagnoses that include status post left carpal tunnel release and previous left wrist fracture with wrist deformity, right wrist overuse with ganglion cyst. The patient currently complains of residual pain that is constant and moderate along with weakness, numbness, tingling and pain that radiates to the hands and fingers. The current request is for Ketoprofen 20% cream 167gm. The treating physician states in the Letter of

Medical Necessity dated 7/24/15 (295B), "I ordered and dispensed the above described medication (Ketoprofen 20% cream 167 grams) ... based upon my examination of the patient and review of the patient history and pertinent data." MTUS Guidelines give a general statement about compounded products: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The current request is for a compounded topical analgesic containing Ketoprofen. MTUS specifically states Ketoprofen is not FDA approved for topical applications. Therefore, any compounded product that contains Ketoprofen is not recommended. The requested treatment is not medically necessary.