

Independent Medical Review Final Determination Letter

1624

[REDACTED]

Dated: 12/20/2013

IMR Case Number:	CM13-0019827	Date of Injury:	11/07/2008
Claims Number:	[REDACTED]	UR Denial Date:	08/28/2013
Priority:	STANDARD	Application Received:	09/03/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED] M.D.		
Treatment(s) in Dispute Listed on IMR Application:			
PLEASE REFERENCE UTILIZATION REVIEW DETERMINATION LETTER			

DEAR [REDACTED] ,

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]
[REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

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

This 51 year old injured worker's original date of injury was 11/7/2008. His injury occurred when "a large stock of heavy windows " fell and struck him. Since the injury, he has chronic right shoulder and elbow pain. In 2008 he had a surgical repair of the tear of his right distal biceps muscle. He has taken tramadol 50 mg and ibuprofen 800 mg for pain, which have not been effective for his pain. He received physical therapy and acupuncture. On exam in July 2012 he exhibited tenderness to palpation over the anterior right shoulder joint. Other provocative maneuvers were negative for tenderness. His diagnoses are right shoulder sprain/strain with impingement syndrome and tendonitis.

IMR DECISION(S) AND RATIONALE(S)

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

1. Ketoprofen with Lidocaine ultra cream 260gm with one refill is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Topical NSAIDs, which is a part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pgs. 111-112, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

A review of the records submitted indicates that this employee has chronic left upper extremity musculoskeletal pain. Ketoprofen is an NSAID and Lidocaine is an anesthetic agent. With this product both will be applied topically. In general, topical agents may be indicated for neuropathic pain when antidepressants and anticonvulsants have failed (MTUS page 111). In addition, "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended."

Topical NSAIDs only show a benefit for the first two weeks of their use. When used to treat osteoarthritis of the knee, there was a benefit over a placebo for up to 12 weeks. Topical Lidocaine may show a benefit when treating neuropathic pain or pain from diabetic neuropathy. It has no indication for chronic musculoskeletal (non-neuropathic) pain. **The request for Ketoprofen with Lidocaine Iultera cream 260gm with one refill is not medically necessary and appropriate.**

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]

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