

Case Number:	CM14-0146340		
Date Assigned:	09/22/2014	Date of Injury:	03/28/2007
Decision Date:	10/23/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	09/09/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 62-year-old male with a reported injury on 03/28/2007. The mechanism of injury was a fall off of a ladder. The injured worker's diagnoses included acromioclavicular separation; status post allograft coracoacromial ligament reconstruction and distal clavicular resection with marked restriction of motion; cervical sprain, superimposed on multilevel degenerative disc disease, nonindustrial; unexamined history of first degree spondylolisthesis, lumbosacral spine, asymptomatic; and a possible complex regional pain syndrome in the right upper extremity. The injured worker's past treatments included medications and physical therapy. The injured worker's diagnostic testing included multiple x-rays. The most recent x-rays were a right shoulder x-ray on 06/01/2010 which showed an abnormal appearance due to the distal clavicle likely related to prior surgery and an old healed injury involving the right 3rd, 4th and possibly 5th ribs. The injured worker also had cervical spine x-ray dated on 06/01/2010 which revealed degenerative disc disease identified at multiple levels being the greatest at C5-6, minimal encroachment upon the neural foramina at C4-5, C5-6, and C6-7 secondary to small spurs, spasm, and no fractures were seen. The injured worker had a nuclear medicine bone scan on 12/07/2010, which demonstrated a faint focal increase of activity in the right clavicle near the glenohumeral junction, but proximal to the acromioclavicular junction, which may represent fracture, probably subacute rather than acute since the intensity is quite mild. No other abnormality was evident. The injured worker's surgical history included an AC joint reconstruction/allograft on 08/24/2007. The injured worker was evaluated on 08/06/2014 for complaints of right shoulder pain that limited his range of motion and activities. The average pain score was 1/10 with medications. The injured worker questioned whether or not the gabapentin was providing adequate relief. The injured worker stopped the Relafen secondary to

some gastrointestinal irritation. The clinician observed and reported tenderness and sensitivity over the right shoulder anterior and posterior aspect. Range of motion was decreased while strength was normal. The clinician's plan was to stop the gabapentin and start Lyrica. The injured worker's medication was gabapentin 600 mg twice per day. The request was for Ketoprofen gel topical 20% twice per day with 3 refills. No rationale for this request was provided. The Request for Authorization form was not provided. Of note, the Ketoprofen gel was prescribed on 06/04/2014. On 07/11/2014, the clinician changed that from the Ketoprofen gel to the Lidocaine patches, and provided the injured worker with 20 patches for trial. On the visit dated 08/06/2014, neither one of these treatment modalities was mentioned.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen gel topical 20% b.i.d. x 3 refills: 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): 111-113.

Decision rationale: The request for Ketoprofen gel topical 20% b.i.d. x 3 refills is not medically necessary. The injured worker did continue to complain of shoulder pain. The California MTUS Chronic Pain Guidelines state that the only topical NSAID recommended for osteoarthritis pain is Voltaren gel 1% indicated for relief of osteoarthritis pain and joints that lend themselves to topical treatment including the ankle, elbow, foot, hand, knee and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. The injured worker was complaining of shoulder pain. The request did not indicate an amount to be applied, a site of application, or a frequency of administration. Additionally, 3 refills would not be indicated without proof of the efficacy of treatment. Therefore, the request for Ketoprofen gel topical 20% b.i.d. x 3 refills is not medically necessary.