

<b>Case Number:</b>	CM14-0165330		
<b>Date Assigned:</b>	10/10/2014	<b>Date of Injury:</b>	08/22/2013
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	09/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2014

### 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 Interventional Spine 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 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:

This patient is a 35 year old male with a date of injury of 8/22/13. The listed diagnoses per [REDACTED]. [REDACTED] are status post fall, trauma brain injury, thoracic spine fracture no. 4, cervical sprain/strain, possible cervical disc injury, lumbar sprain/strain, possible lumbar disc injury, left frontal hemorrhage and decrease in hearing. According to progress report 9/4/14 by [REDACTED] the patient presents with ongoing low back pain that radiates into his hip. Examination revealed Lumbosacral tenderness to palpation, and painful range of motion. Deep tendon reflexes are 2+ in the bilateral lower extremities. The treater is requesting a refill of Ketoprofen Cream 20% #1 tube. Utilization review denied the request on 9/25/14. Treatment reports from 4/15/14 through 9/4/14 were provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketoprofen Cream 20 percent, #1 tube:** 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 analgesic Page(s): 111-113.

**Decision rationale:** This patient presents with ongoing low back pain that radiates into his hip. The treater is requesting a refill of Ketoprofen Cream 20%, #1 tube. In the 9/4/14 report, the treater states that the patient requires Ketoprofen "as he finds it beneficial." The MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." Under Ketoprofen, MTUS states, "This agent is not currently FDA approved for a topical application." The request is not medically necessary.