

<b>Case Number:</b>	CM14-0004835		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	03/19/2012
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	12/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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. 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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency Medicine

### 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 33 year old male who sustained an industrial related injury on 3/19/12 when a heavy tire fell onto him. The injured worker had complaints of low back pain that radiated to bilateral lower extremities. Thoracic and right shoulder pain was also noted. Diagnoses included cervical radiculitis, thoracic radiculitis, cervical sprain/strain, lumbar sprain/strain, thoracic sprain/strain, right shoulder pain, bilateral carpal tunnel syndrome, and chronic pain. A physician noted the injured worker had failed conservative treatment, which included drug therapy, activity modifications, and physical therapy. The treating physician requested authorization for Ketoprofen 75mg #60. On 12/20/13, the request was non-certified. The utilization review physician cited the Medical Treatment Utilization Schedule guidelines and noted there was no documentation of functional restoration to support continuing anti-inflammatory medication use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**KETOPROFEN 75 MG 1 TABLET BY MOUTH, TWICE A DAILY #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-INFLAMMATORY MEDICATIONS Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-69.

**Decision rationale:** Guidelines recommend NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. In addition, documentation is required regarding pain and function with the use of this medication in chronic pain. In this case, there is no documentation that suggests that Ketoprofen is providing analgesic benefits or any objective functional improvement. Thus, the request for Ketoprofen 75 mg #60 is not medically appropriate and necessary.