

<b>Case Number:</b>	CM14-0195285		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	11/04/2008
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	11/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2014

### 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 Emergency 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 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:

Patient with reported date of injury on 11/4/2008. Mechanism of injury is described as a direct blow to back. Patient has a diagnosis of R shoulder rotator cuff injury, R shoulder pain, cervical sprain/strain, cervical radiculopathy, lumbosacral degenerative disease with radiculopathy. Patient is post R shoulder surgery x2; L shoulder surgery x2, bilateral foot surgeries and bilateral knee surgeries. Medical reports reviewed. Last report available until 10/10/14. Patient complains of R shoulder pain, low back and neck pain. Pain worsens with activity and radiates down both lower extremities. Objective exam reveals normal gait. R shoulder with tenderness, limited range of motion (ROM) and pain. Strength is normal. Cervical spine with noted myofascial tightness with painful ROM and positive Spurling's bilaterally. Low back with noted tenderness and tightness. Decreased ROM. Straight leg raise is positive bilaterally. Medications include Norco, Lyrica, Prilosec, Valium and ketoprofen cream. Independent Medical Review is for Ketoprofen cream. Prior UR on 11/21/14 recommended non-certification.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketoprofen Cream:** 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:** As per MTUS guidelines topical creams are considered experimental with poor evidence to support efficacy or use. Topical NSAIDs have no efficacy in spinal pain. Ketoprofen is an NSAID. It is not FDA approved for topical applications. The use of a non-FDA approved application of a medication when there are multiple other topical NSAIDs is not medically necessary. Ketoprofen compounded product is not medically necessary.