

<b>Case Number:</b>	CM15-0102913		
<b>Date Assigned:</b>	06/05/2015	<b>Date of Injury:</b>	06/07/2013
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/28/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 61 year old female, who sustained an industrial injury on 1/28/2013. Diagnoses include thoracic sprain/strain and right shoulder arthralgia. Treatment to date has included surgical intervention, physical therapy, chiropractic treatment, acupuncture, injections, transcutaneous electrical nerve stimulation (TENS) unit, icing and medications. EMG (electromyography) of the bilateral upper extremities dated 4/21/2014 was read as a normal study. Per the Primary Treating Physician's Progress Report dated 4/01/2015, the injured worker reported right shoulder pain that has decreased since the time of surgery, however it is not better than it was before surgery. She reports upper back pain that in the right scapular region rated as 4/10. She also reported radiation of numbness and tingling in the right upper extremity which has decreased significantly since the right shoulder surgery. Physical examination revealed diffuse tenderness to palpation of the thoracic paraspinal muscles, right much more severe than left. There was tenderness over the subscapular region on the left. Range of motion was decreased throughout the cervical, thoracic and lumbar spine. Right shoulder range of motion was decreased in every plane with abduction being the most severe. The plan of care included continuation of medications and authorization was requested for Ketoprofen 20%.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CM3 Ketoprofen 20%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics` Page(s): 112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111-113.

**Decision rationale:** The MTUS Guidelines recommend the use of topical analgesics as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. These guidelines report that topical ketoprofen is not FDA approved, and is therefore not recommended by these guidelines. The request for CM3 Ketoprofen 20% is determined to not be medically necessary.