

<b>Case Number:</b>	CM15-0023238		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	06/20/2010
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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: Utah, Arkansas

Certification(s)/Specialty: Family Practice

### 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 56 year old female who sustained a work related injury on June 20, 2010. Treatment consisted of knee brace, ice, physical therapy, viscosupplementation injections and pain medications. X rays revealed degenerative joint disease. She had incurred a closed fracture of the humerus and had an Open Reduction and Internal Fixation of the left humerus performed and had a left wrist fracture with an Open Reduction and Internal Fixation performed with an external fixator placed. Currently, the injured worker complained of left shoulder pain, stiffness, weakness and decreased range of motion and bilateral knee pain, stiffness, swelling and weakness in both knees. On January 29, 2015, a request for a prescription of Ketoprofen 10% was non-certified by the California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketoprofen 10%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 112. Decision based on Non-MTUS Citation Official Disability Guidelines: Work Loss Data Institute, LLC; Corpus Christi,

TX: Section Knee & Leg (Acute & Chronic) updated 10/27/2014. ODG; Shoulder (Acute & Chronic) updated 10/31/2014.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chapter: Topical Analgesics, page(s) 112.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for a topical compound. MTUS guidelines state the following: Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. According to the clinical documentation provided and current MTUS guidelines; Any compound that contains Ketoprofen as a topical is not indicated as a medical necessity to the patient at this time.