
Notice of Independent Medical Review Determination

Dated: 9/20/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/12/2013
Date of Injury:	5/7/2003
IMR Application Received:	7/18/2013
MAXIMUS Case Number:	CM13-0001954

- 1) MAXIMUS Federal Services, Inc. has determined the request for CM3 Ketoprofen 20% **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/22/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for CM3 Ketoprofen 20% **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 12, 2013.

BRIEF CLINICAL SUMMARY:

This year-old 57 female was injured 5/7/03. The mechanism of injury was not provided to this reviewer. The carrier has accepted the claim for left shoulder/upper and lower arm/knee, right wrist/hand/knee. No diagnostics have been reported to this reviewer. No surgery has been reported to this reviewer relative to this injury. The requesting provider's medical report dated 6/6/13 stated that the patient complained of ongoing bilateral knee symptoms and right hand numbness and tingling. She continues to get worse with time and is concerned about her condition. The right thumb spica brace has been helping. Rates her pain at 5-6/10. Objective: Right knee: Range of motion 0 to 120 degrees. Positive tenderness to palpation over the medial

joint line. Positive painful patellofemoral crepitus. Minimal swelling. 4+/5 quad/hamstring strength. Left Knee: Range of motion is 0 though 120 degrees with no sign of infection. No sign of DVT in left lower extremity. Painful patellofemoral crepitus as well as medial joint line crepitus with motion. Right wrist: Positive grind test, carpal tunnel test, Tinel's and Phalen's. 5-/5 grip strength. X-rays of the right wrist done on 04/23/2013 show mild carpal tunnel DJD and mild CMC DJD. Diagnosis: Status post bilateral knee arthroscopies, 2007 left knee and 2010 for right knee. Bilateral knee chondromalacia patella. Bilateral knee osteoarthritis/DJD. Antalgic gait with need for assistive device with distance walking. NSAID induced gastritis. Right carpal tunnel syndrome, not electro diagnostically supported at this time. Right CMC, DJD. Plan and request: CM3-Ketoprofen.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review
- Utilization Review from Claims Administrator

- Medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for CM3 Ketoprofen 20%:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine, 2nd Edition (2004), Table 3-1, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Chronic Pain Medical Treatment Guidelines (2009), which are part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines section used by the Claims Administrator.

Rationale for the Decision:

The employee was injured on 5/7/2003. A progress note dated 06/25/2013 indicates right knee range of motion was 0 to 120 degrees with positive tenderness to palpation over the medial joint line. A right wrist exam showed full range of motion throughout the wrist with a positive CMC grind test. The employee had a positive compression test, positive Tinel's, and positive Phalen's. The employee's diagnoses include bilateral knee chondromalacia of the patella, bilateral knee osteoarthritis, non-steroidal anti-inflammatory drug (NSAID) induced gastritis, and right carpal tunnel syndrome. A request was submitted for CM3 Ketoprofen 20%.

The MTUS Chronic Pain Guidelines do not advocate the use of topical NSAIDs, as the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Also, Ketoprofen is not currently FDA approved for topical application. The request is not supported by the guideline. The request for CM3 Ketoprofen 20% is not medically necessary and appropriate.

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/sab

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.