

<b>Case Number:</b>	CM14-0011141		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	04/12/2002
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	12/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2014

### 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 Physical Medicine and Rehabilitation, and is licensed to practice in Texas. 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:

The injured worker is a 54 year old female who reported an injury on 4/12/02. The mechanism of injury is unknown. The injured worker complained of neck pain with radiation down the right arm. She rated her pain at 9/10. On physical findings the injured worker was noted to have tenderness in the right paraspinals and trapezius. Active range of motion showed flexion of the right 160 degrees, flexion of the left 170 degrees, abduction on the right of 160 degrees, 170 degrees on the left, internal rotation 50 degrees on the right, 60 degrees on the left, external rotation on the right of 70 degrees and 70 degrees on the left. The injured worker had prior treatments to include acupuncture and medication. Medications include Vicodin, Zantac, Soma, Naproxen, and Cymbalta. The injured worker has diagnoses of moderate degenerative disc disease, chronic cervicothoracic strain with rhdiculitis, right shoulder arthroscopic decompression with partial claviclectomy, right shoulder possible partial thickness rotator cuff tear, right elbow lateral epicondylitis, and chronic right wrist sprain with early carpal tunnel syndrome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE (DOS 12-6-13) USAGE OF KETOPROFEN/MENTHOL/CAPSAICIN 1X6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

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

**Decision rationale:** California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The MTUS guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The MTUS guidelines state that there have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The proposed cream contains a 0.0375% formulation of capsaicin. The guidelines state that Ketoprofen is not currently FDA approved for a topical application. In addition, the dose, quantity and frequency for the proposed medication were not provided. The proposed compounded product is not recommended. As such, the request is not medically necessary.