

<b>Case Number:</b>	CM14-0135985		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	04/20/2008
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	08/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2014

### 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 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:

The injured worker is a 56-year-old male who reported an injury on 04/20/2006. The mechanism of injury was noted to be prolonged repetitive injury. The injured worker had a diagnosis of bilateral carpal tunnel syndrome, status post carpal tunnel release surgery, repetitive strain injury, myofascial pain syndrome, and bilateral shoulders and elbows strains. He was noted to have prior treatments of chiropractic care, acupuncture, physical therapy, massage therapy, home exercises, and medications. Diagnostic image testing included electromyography and MRI. Surgical history included carpal tunnel release in 2010. A clinical evaluation on 07/21/2014 noted the injured worker with subjective complaints of pain in the arms, shoulders, and hands bilaterally. He rated pain at 7/10. He indicated pain was aggravated by the arm function, hand function, and activity. In addition, the injured worker described his pain as a tingling sensation in the arm, wrist, and hand. The treatment plan was for an EMG of the upper extremity and nerve conduction study, acupuncture, and chiropractic treatments, in addition to Ketoprofen cream. The provider's rationale for the request was noted within the treatment plan of the clinical evaluation on 07/21/2014. A Request for Authorization form was not provided for the Ketoprofen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketoprofen cream two times a day as needed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): pages 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines indicate Ketoprofen is a non-FDA approved agent for a topical application. The guidelines continue to state that any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The clinical documentation submitted for review does not state failure of a trial for antidepressants or anticonvulsants. The provider's request does not indicate a quantity or a dosage. Therefore, the request for Ketoprofen cream 2 times a day as needed is not medically necessary.