

<b>Case Number:</b>	CM14-0053499		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	10/12/2010
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	03/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2014

### 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 & Rehabilitation, and is licensed to practice in Texas and Oklahoma. 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 72-year-old male who reported an injury on 10/12/2010. The mechanism of injury was not provided in the medical records. His diagnoses were noted to include lumbar spine sprain/strain with right lower extremity radiculitis and right shoulder impingement syndrome. His past treatments were noted to include medications, epidural steroid injections, and topical analgesics. On 03/18/2014, the injured worker presented with complaints of pain in the right shoulder and the lumbar spine with radiation to the bilateral lower extremities. His physical examination revealed tenderness to palpation of the lumbar spine with positive muscle spasms, decrease range of motion in the lumbar spine, a positive straight leg raise on the left, decreased sensation in the left leg, and decreased range of motion in the right shoulder. His medications were noted to include nortriptyline, tramadol, and Ambien. The treatment plan was noted to include an unspecified lumbar spine surgery, Menthoderm topical gel, and ketoprofen compounded cream. A clear rationale for the requested ketoprofen cream was not provided. The Request for Authorization form was submitted on 03/21/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketoprofen compound cream 20%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Nonsteroidal anti-inflammatory medications.

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

**Decision rationale:** According to the California MTUS Chronic Pain Guidelines, ketoprofen is not currently FDA approved for topical application as it has an extremely high incidence of photocontact dermatitis. The guidelines specify that FDA approved topical NSAIDs are indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment, but have not been evaluated for treatment of the spine, hip, or shoulder. The clinical information submitted for review indicated that the patient was seen regarding shoulder and lumbar spine pain on 03/18/2014, and was recommended for topical ketoprofen. As topical NSAIDs have not been evaluated for the spine or shoulder, the request would not be supported. In addition, the guidelines specifically state that topical ketoprofen is not FDA approved due to its high incidence of photocontact dermatitis. In addition, the request failed to provide a frequency and quantity. Based on the above, the request for ketoprofen compound cream 20% is not medically necessary.