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| <b>Case Number:</b>   | CM14-0109699 |                              |            |
| <b>Date Assigned:</b> | 08/13/2014   | <b>Date of Injury:</b>       | 12/22/2005 |
| <b>Decision Date:</b> | 11/21/2014   | <b>UR Denial Date:</b>       | 06/21/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/15/2014 |

### 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, has a subspecialty in Interventional Spine 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 patient is a 50 year old female with an injury date of 12/22/05. The 05/27/14 progress report by [REDACTED] states that the patient presents with neck, lower back, left shoulder, left wrist and hand pain with weakness and decreased range of motion. The patient is working with restrictions. Examination of the lumbar spine shows limited range of motion with tenderness over the trapezius/paravertebrals, left greater than right. Shoulder depression is positive and Spurling's is positive on the left. Strength and sensation are 4/5 on the left at C5, C6, C7 and C8. For the left shoulder there is limited range of motion with tenderness over the acromioclavicular joint. Examination of the left wrist/hand reveals limited range of motion with Phalen's and Tinel's sign positive. Sensation is 4/5 in the median and ulnar distribution. The patient's diagnoses include: Chronic lumbosacral strain with history of disc herniation, worsening Left shoulder rotator cuff syndrome, status post arthroscopy with worsening pain and function. The report states the patient is has not been using medications as they have not been approved. As of the 05/27/14 she is prescribed to restart Ibuprofen and Prilosec. The utilization review being challenged is dated 06/21/14. Reports were provided from 12/26/13 to 05/27/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kera-tek analgesic gel 4oz:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Page(s): 105.

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

**Decision rationale:** The patient presents with neck, lower back, left shoulder, left wrist and hand pain. The treater requests for Keta-tek analgesic gel 4 oz. The reports provided indicate the patient is starting this medication. MTUS page 111 of the chronic pain section states the following regarding topical analgesics: 'Largely experimental in use with few randomized controlled trials to determine efficacy or safety.' 'There is little to no research to support the use of many of these agents.' Topical NSAIDs are indicated for peripheral joint arthritis/tendinitis. The medication is a compound analgesic containing 28% Methyl Salicylate and 16% Menthol. The treater states about this medication in the 05/27/14 report, "...request the Kerat-tek analgesic gel as recommended per MTUS Guidelines for chronic pain in attempt to control her pain and aid her gastrointestinal symptoms secondary to her use of NSADs." The report further states regarding this medication, "The patient does continue with chronic pain affecting her cervical spine, left shoulder and lumbar spine. The patient has been intolerant to other treatment including activity restrictions, medications, and home exercises and does remain significantly symptomatic. At this time, I am prescribing Kera-tek gel to maintain the patient's painful symptoms, restore activity levels and aid in functional restoration." In this case, the treater states above the medication is for chronic pain affecting the cervical spine, left shoulder and lumbar spine. This medication is indicated for peripheral joint arthritis/ tendinitis. Recommendation is for denial.