

<b>Case Number:</b>	CM14-0154992		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	07/17/2006
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	09/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2014

### 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 Emergency Medicine, 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:

This is a patient with a reported date of injury of 7/17/2006. No mechanism of injury was provided for review. The patient has a diagnosis of right shoulder rotator cuff syndrome, left shoulder rotator cuff syndrome post repair and distal clavicle excision, cervical disc herniation post cervical discectomy and fusion, chronic thoracic pain and overuse syndrome. The patient complains of cervical spine, thoracic spine and bilateral shoulder and wrist pain. Pain is 7/10 improves to 3-4/10. Objective exam reveals cervical spine tenderness from paraspinal to trapezius. There is decreased range of motion (ROM). There is positive cervical compression and Spurling bilaterally. There is decreased strength of 4/5 bilaterally at C5-C8 with normal sensation. The thoracic spine has tenderness and decreased ROM. The bilateral shoulders have decreased ROM and tenderness. The patient has decreased strength. There is a positive Hawkins bilaterally and Neer's on the left side. There were no imaging or electrodiagnostic reports provided for review. The medication list includes Norco and Keratek gel. No other medications were noted on records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 KERA TEK ANALGESIC GEL, 4 OZ, QTY 1, UNSPECIFIED DAYS SUPPLY, 0 REFILL, RELATED TO CERVICAL SPIE, THORACIC SPINE, RIGHT SHOULDER, BILATERAL UPPER EXTREMITY SYMPTOMS/ INJURY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

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

**Decision rationale:** Keratek gel is composed of methyl-salicylate and menthol. As per MTUS guidelines, "Any compounded product that contains one drug or drug class that is not recommended is not recommended." As per the MTUS Chronic Pain Medical Treatment Guidelines, Methyl-Salicylate is recommended for osteoarthritis, especially of the knee. It may be recommended for certain chronic musculoskeletal pains and recommendation is for short term use. There is no evidence to support its use in the shoulder or neck and patient has been on this medication chronicle with no documentation of improvement in pain. Menthol has some topical soothing affect. Since Methyl-Salicylate is not recommended, Keratek gel is not recommended, and the request is not medically necessary.