

<b>Case Number:</b>	CM14-0088871		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	10/11/2006
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	05/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2014

### 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 Internal Medicine, has a subspecialty in Rheumatology and is licensed to practice in Maryland. 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 male with date of injury 10/11/06. The mechanism of injury is not listed. The patient has complained of neck, low back and right shoulder pain since the injury. He has had right shoulder rotator cuff repair and has also been treated with physical therapy and medications. MRI of the cervical spine performed in 03/2013 revealed multilevel disc disease at C5-C7, moderate to severe left and moderate right foraminal narrowing at C5-6 and moderate left and mild right neuroforaminal narrowing at C6-7. Objective documentation noted: decreased and painful range of motion of the cervical spine, positive cervical spine compression test, positive Spurling's test on the right, tenderness to palpation of the lumbar paraspinal musculature, positive straight leg raise on the right and decreased and painful range of motion of the right shoulder. Diagnoses to date include: cervicogenic disc disease with neuroforaminal stenosis, lumbar spine disc disease, right shoulder status post rotator cuff repair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kera-Tek Gel one tube between 4/10/2014-08/07/2014.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** This 50 year old male has complained of neck, low back and right shoulder pain since the date of injury 10/11/06. He has had right shoulder rotator cuff repair and has also been treated with physical therapy and medications. The current request is for Kera-Tek gel. Per the MTUS guideline cited above, "the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anticonvulsants and antidepressants have failed." There is no such documentation in the available medical records and the request does not meet the MTUS guidelines cited above. Therefore, the Kera-Tek gel is considered not medically necessary.