

<b>Case Number:</b>	CM14-0192555		
<b>Date Assigned:</b>	11/26/2014	<b>Date of Injury:</b>	05/14/2012
<b>Decision Date:</b>	01/12/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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 and is licensed to practice in New York. 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 claimant is a 59 year old female who sustained an industrial injury on 05/14/2012. The mechanism of injury occurred after a trip and fall accident. Her diagnoses included lumbar strain and degenerative disc disease with left leg radiculopathy and bilateral shoulder strain r/o rotator cuff tear. She continues to complain of 7-8/10 low back pain but denies new weakness or numbness. Physical exam showed 5/5 muscle strength and intact sensation. Treatment has included medications including topical analgesics, physical therapy hot/cold packs and, massage. The treating provider has requested one bottle of Kera-Tek analgesic gel, Naprosyn Sodium 550mg, and Prilosec 20mg # 60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One bottle of Kera-Tek analgesic gel (unspecified Quantity): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics.

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

**Decision rationale:** There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily

recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control ( including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, gamma agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug ( or drug class) that is not recommended is not recommended. There is lack of scientific evidence to support the use of topical menthol and methyl salicylate gel for the treatment of chronic back and shoulder pain. Medical necessity for the requested item is not established. One bottle of Kera-Tek analgesic gel is not medically necessary.

**Naprosyn sodium 550mg (unspecified Quantity):** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67.

**Decision rationale:** The requested medication, Naprosyn is medically necessary for the treatment of the claimant's pain condition. Naprosyn is a non-steroidal anti-inflammatory medication ( NSAID). These medications are recommended for the treatment of chronic pain as a second line therapy after acetaminophen. The documentation indicates the claimant has significant low back and bilateral shoulder pain and the medication has proved beneficial for pain control. Medical necessity for the requested item has been established. The requested Naprosyn sodium 550mg is medically necessary.

**Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** Per California MTUS 2009 proton pump inhibitors are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any symptoms or GI risk factors. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants or high dose/multiple NSAID. The claimant has no documented GI issues. Based on the available information provided for review, the medical necessity for Prilosec has not been established. The requested Prilosec 20 mg is not medically necessary.