

<b>Case Number:</b>	CM15-0163020		
<b>Date Assigned:</b>	08/31/2015	<b>Date of Injury:</b>	05/13/2014
<b>Decision Date:</b>	10/05/2015	<b>UR Denial Date:</b>	07/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 41 year old female with a May 13, 2014 date of injury. A progress note dated July 13, 2015 documents subjective complaints (persistent pain in the cervical spine rated at a level of 7 out of 10; lumbar spine pain rated at a level of 8 out of 10; right wrist pain rated at a level of 6 out of 10), objective findings (tenderness to palpation of the cervical spine; tenderness to palpation over the volar compartment of the right wrist; tenderness to palpation of the lumbar spine; limited range of motion of the lumbar spine), and current diagnoses (cervical strain, rule out disc herniation; lumbar strain, rule out disc herniation; partial tear through the central portion of the triangular fibrocartilage complex; ganglion cysts in the wrist). Treatments to date have included medications and imaging studies. The treating physician requested authorization for Kera-Tek analgesic gel, Anaprox 550mg #120, and Ultram 50mg #120.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kera-Tek analgesic gel:** Overturned

**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:** The claimant sustained a work injury in May 2014 and is being treated for neck, low back, and right wrist pain. When seen, she was having constant pain rated at 6-8/10. Physical examination findings included cervical and lumbar spine tenderness with decreased lumbar flexion. There was right wrist tenderness with normal range of motion. There was a normal gait. At a previous visit, Lidoderm is referenced as decreasing pain. Tramadol had been prescribed previously but had been discontinued due to a possible allergic reaction. It had been prescribed at a total MED (morphine equivalent dose) of 30 mg per day. The claimant has a history of NSAID induced gastritis. The active ingredients of Keratek gel are menthol and methyl salicylate. Menthol and methyl salicylate are used as a topical analgesic in over the counter medications such as Ben-Gay or Icy Hot. Topical non-steroidal anti-inflammatory medication can be recommended for patients with chronic pain where the target tissue is located superficially in patients who either do not tolerate, or have relative contraindications, for oral non-steroidal anti-inflammatory medications. In this case, the claimant has localized wrist pain and oral non-steroidal anti-inflammatory medication would be relatively contraindicated due to her history of gastritis. Generic medication is available. The request is medically necessary.

**Anaprox 550mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen (Naprosyn). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Anti-inflammatory medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 67-70.

**Decision rationale:** The claimant sustained a work injury in May 2014 and is being treated for neck, low back, and right wrist pain. When seen, she was having constant pain rated at 6-8/10. Physical examination findings included cervical and lumbar spine tenderness with decreased lumbar flexion. There was right wrist tenderness with normal range of motion. There was a normal gait. At a previous visit, Lidoderm is referenced as decreasing pain. Tramadol had been prescribed previously but had been discontinued due to a possible allergic reaction. It had been prescribed at a total MED (morphine equivalent dose) of 30 mg per day. The claimant has a history of NSAID induced gastritis. Oral NSAIDs (nonsteroidal antiinflammatory medications) are recommended for treatment of chronic persistent pain including chronic low back pain. Dosing of Anaprox (naproxen) is 275-550 mg twice daily and the maximum daily dose should not exceed 1100 mg. The claimant has a history of gastritis and would be considered at intermediate risk for a gastrointestinal event. For a patient at intermediate risk, guidelines recommend against prescribing a nonselective NSAID medication and the dose being requested is twice that recommended. Prescribing Anaprox is not medically necessary.

**Ultram 50mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (1) Opioids, criteria for use, (2) Opioids, dosing Page(s): 76-80, 86.

**Decision rationale:** The claimant sustained a work injury in May 2014 and is being treated for neck, low back, and right wrist pain. When seen, she was having constant pain rated at 6-8/10. Physical examination findings included cervical and lumbar spine tenderness with decreased lumbar flexion. There was right wrist tenderness with normal range of motion. There was a normal gait. At a previous visit, Lidoderm is referenced as decreasing pain. Tramadol had been prescribed previously but had been discontinued due to a possible allergic reaction. It had been prescribed at a total MED (morphine equivalent dose) of 30 mg per day. The claimant has a history of NSAID induced gastritis. Ultram (tramadol) is an immediate release short acting medication often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management. Although there are no identified issues of abuse or addiction and the total MED is less than 120 mg per day, there is no documentation that this medication is providing decreased pain, an increased level of function, or improved quality of life. Continued prescribing is not medically necessary.