

<b>Case Number:</b>	CM15-0035404		
<b>Date Assigned:</b>	03/03/2015	<b>Date of Injury:</b>	01/04/2013
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	02/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 injured worker is a 44-year-old female, who sustained an industrial injury on 01/04/2013. The diagnoses have included acute cervical strain, acute lumbar strain, acute left shoulder strain, acute bilateral elbow strain, acute right wrist strain, right knee contusion, right partial thickness tear of supraspinatus tendon, right shoulder sublabral recess versus a superior and anterior labral tear, right mild compression of the ulnar nerve per nerve conduction studies dated 11/22/2013, and right shoulder rotator cuff repair. Noted treatments to date have included physical therapy and medications. Diagnostics to date have included right wrist x-ray on 08/12/2014, which was unremarkable. In a progress note dated 01/26/2015, the injured worker presented with complaints of lumbar spine, left shoulder, and bilateral wrist pain. The treating physician reported the injured worker is awaiting schedule for the right wrist and right elbow surgery and seeking authorization for an extension on Kera-Tek analgesic gel. Utilization Review determination on 02/10/2015 non-certified the request for Kera-Tek Analgesic Gel 4oz citing Medical Treatment Utilization Schedule Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kera-Tek Analgesics Gel 4oz:** 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:** Kera-Tek analgesic gel was requested. Kera-Tek has active ingredients of methyl salicylate and menthol. Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic compound over oral NSAIDs or other pain relievers for a patient with spinal and multiple joint pain without contraindication in taking oral medication. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic for this chronic injury beyond guidelines criteria. The Kera-Tek Analgesics Gel 4oz is not medically necessary and appropriate.