

Case Number:	CM14-0216000		
Date Assigned:	01/06/2015	Date of Injury:	06/14/2000
Decision Date:	02/28/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	12/24/2014

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. 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 patient is a 53-year-old female with an injury date of 06/14/2000. Based on the 07/10/2014 progress report, the patient complains of neck pain which radiates to her head and upper back, pressure-like right shoulder pain, and lower back pain which radiates to the midback and right lower extremity. She rates her pain as a 5/10. The 10/14/2014 report indicates that the patient has constant, slight to moderate cervical spine pain, constant slight to moderate right shoulder pain, and moderate to severe lumbar spine pain. In regards to the cervical spine, the patient has a loss of range of motion, palpable tenderness, and hypertonicity. The right shoulder has a loss of range of motion, palpable tenderness, and hypertonicity. For the lumbar spine, the patient has a loss of range of motion, palpable tenderness, and hypertonicity. The 11/13/2014 report states that the patient rates her lower back pain as a 9/10. She states that her right leg gave out due to weakness/pain from the lower back, and she fell on both legs. Palpation revealed tenderness/hypertonicity over the suboccipital, cervical paravertebral and levator scapulae muscles bilaterally. She also has tenderness over the trapezius muscles bilaterally. Palpation of the trapezius and subacromial spine revealed tenderness on the right, palpation of the biceps tendon revealed tenderness in the right, and palpation of the parascapular musculature revealed tenderness and hypertonicity on the right. Supraspinatus, Neer impingement, and Hawkins impingement tests were all positive on the right. For the lumbar spine, palpation revealed tenderness and hypertonicity over the lumbar paraspinal muscles and gluteal muscles bilaterally, as well as tenderness over the quadratus lumborum bilaterally. Straight leg raise test is positive bilaterally, right greater than left. The patient's diagnoses include the following: 1. Cervical

spine sprain/strain. 2. Lumbar disk herniation with lower extremity radiculopathy. 3. Status post nucleoplasty. 4. Right shoulder impingement syndrome. 5. Status post right shoulder arthroscopy. 6. Fall secondary to weakness of the right leg. 7. Lumbar spine re-aggravation secondary to fall in November 2014. The utilization review determination being challenged is dated 12/05/2014. There are 4 treatment reports provided from 06/12/2014 - 11/13/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

(1) Prescription of Kera-Tek analgesic gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications, Salicylate topical.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Low Back Chapter, Biofreeze 1/2 cryotherapy gel

Decision rationale: On page 111, under topical analgesics, MTUS gives a general statement about compounded products: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS has support for methyl salicylate under the Topical Salicylate section, but does not specifically address the menthol. ODG guidelines were consulted. ODG guidelines, Low Back Chapter under Biofreeze cryotherapy gel, states the active ingredient in Biofreeze is menthol and that it is recommended for acute pain and takes the place of an ice pack for cryotherapy. In this case, the patient is not in the acute phase, and the use of menthol for a chronic condition is not in accordance with the ODG recommendations. Menthol would not be recommended for a chronic condition, so the whole compounded product that contains Menthol, is not recommended. The request of the KeraTek gel IS NOT medically necessary.