

<b>Case Number:</b>	CM14-0076124		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	02/17/2012
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	04/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/23/2014

### 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 Occupational Medicine and is licensed to practice in California. 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 30 year old male who was injured on 02/17/2012 due to a collision or burn mechanism. Prior treatment history has included chiropractic therapy and physical therapy, laser therapy and interferential unit. Initial ortho evaluation note dated 04/16/2014 indicates the patient presented with constant pain to the back of his neck radiating to his shoulders. He indicated constant bilaterally upper extremity pain associated with numbness and tingling, weakness, coldness, grip loss, and cramping. On exam, deep tendon reflexes were 1-2+. His sensation was decreased about the left 5th finger. He is diagnosed with status post head and facial trauma with facial, orbital fracture with concussion; post concussion syndrome and probable post-traumatic vestibular dysfunction. No further information has been provided pertaining to the requested medication. Prior utilization review dated 04/25/2014 states the request for Keratek Cream is denied as there is no documentation of failed first line agents and the frequency of utilizing this cream is not documented.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Keratek Cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Low back Topical analgesics.

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

**Decision rationale:** This is a request for Keratek cream, a topical analgesic containing menthol and methyl salicylate. According to MTUS guidelines, topical NSAIDs are recommended for short-term treatment of tendinitis or osteoarthritis after failure of first-line oral medications. Topical NSAIDs are not recommended for the spine or shoulders. However, in this case there is no documentation of tendinitis or osteoarthritis in joints amenable to topical treatment. Such as, Keratek Cream is not medically necessary.