

<b>Case Number:</b>	CM14-0189456		
<b>Date Assigned:</b>	11/20/2014	<b>Date of Injury:</b>	08/27/2013
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	10/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 57 year old male with an injury date of 08/27/13. Based on the 10/02/14 and 09/15/14 progress reports, the patient complains of thoracic lumbar spine pain. The pain level is at 7 out of 10. The patient has tenderness, decreased motion, sensation and loss of strength to the lumbar spine. X-rays were taken of the thoracic spine and lumbar spine dated 05/13/14 show loss of lumbar lordosis. The patient had undergone lumbar spinal stenosis, lumbar spondylolisthesis L3-4, and facet cyst on 05/22/14. His diagnoses include following: 1. Lumbar Intervertebral Disc Displacement without Myelopathy; Lumbago or Sciatica Due to Displacement of Intervertebral Disc; Neuritis or Radiculitis Due to Displacement or Rupture of Lumbar Intervertebral Disc 2. Spinal Stenosis; lumbar region The patient remains off work until 11/20/14. The treating physician is requesting for Keratek gel 4oz bottle for pain and inflammation (apply 1-2 grams, 2-3 times a day as directed, no refills) per 09/15/14 and 10/02/14 reports. The utilization review determination being challenged is dated 10/08/14. The treating physician provided treatment reports from 05/12/14-10/02/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Keratek gel 4 Oz bottle, apply 1-2 grams, 2-3 times a day or as directed, no refills, for pain inflammation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Salicylate Topicals Page(s): 105, 112, 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

**Decision rationale:** This patient presents with thoracic lumbar spine pain. The request is for Keratek gel 4oz bottle for pain and inflammation (apply 1-2 grams, 2-3 times a day as directed, no refills). No reports provided indicate that the patient has previously used this medication. MTUS guidelines on topical analgesics page 111 (chronic pain section) states the following: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. For topical NSAIDs, it is only recommended for peripheral joint arthritis/tendinitis problems. In this case, Kera Tek Gel is a compound analgesic containing 28% Methyl Salicylate and 16% Menthol. The treater does not provide any discussion regarding the efficacy and use of this topical product. Topical NSAIDs are indicated for peripheral joint arthritis/tendinitis which this patient does not present with. The request is not medically necessary.