

<b>Case Number:</b>	CM14-0092331		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	02/19/1993
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	06/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2014

### 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 Internal 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 injured worker is a 76 year old male who is reported to have a date of injury of 02/19/93. The mechanism of injury is not discussed. It is reported that he has mid and low back pain with progressive stiffness. He is noted to have progressive unremitting joint ankylosis. It is reported that he has a progression of ankylosing in the cervical region with paresthesia down the arm secondary to stenosis from the vertebral foramina at C4, C5, and C6. Records indicate that he has received extensive passive modalities and chiropractic manipulation. The records indicate that the injured worker has been prescribed Theraflex cream 120mg and Keratek gel. The record includes a utilization review determination dated 06/04/14 in which requests for Theraflex cream 120mg and Keratek gel 4 oz. were non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Theraflex Cream 120mg:** 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): 111-114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**Decision rationale:** The request for Theraflex cream 120mg is not supported as medically necessary. Theraflex is an unstudied topical analgesic. The components of this cream are not readily determined. The California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US FDA do not recommend the use of topical analgesics as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. The components of this cream are not documented. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.

**Keratek 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): 111-114.

**Decision rationale:** The request for Keratek gel 4 oz. is not supported as medically necessary. The California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US FDA do not recommend the use of topical analgesics as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. As such, the medical necessity is not established.