

<b>Case Number:</b>	CM15-0022874		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	05/12/2013
<b>Decision Date:</b>	06/17/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 70 year old female, who sustained an industrial injury on 5/12/13. She has reported initial complaints of low back injury after reaching for a case on the top shelf and it fell forward towards her. The diagnoses have included lumbar sprain with lower extremity radiculitis, lumbar disc herniation, lumbar spinal stenosis and lumbar spondylolisthesis. Treatment to date has included medications, diagnostics, activity modifications, radiofrequency ablation. Currently, as per the physician progress note dated 1/7/15, the injured worker complains of low back pain with continued throbbing and she can't sit, stand or lie down for long periods. There are complaints of occasional pain in the thighs. The objective findings reveal tenderness over the lumbar area centrally. There are no other documented findings noted for that visit. The current medications included Ibuprofen as needed, Tramadol, Karatek gel and Lidoderm patches. There is no urine drug screen report noted in the records and there is no diagnostic testing results noted within the records. The treatment plan is for consult and treatment with urologist regarding incontinence, pain management consult; obtain the Magnetic Resonance Imaging (MRI) of the lumbar spine, and mediations. Work status is to remain off work until 2/8/15. The physician requested treatment included Keratek Gel 4oz #113 with 3 refills for pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Keratek Gel 4oz #113 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topical, topical analgesic Page(s): 105.

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

**Decision rationale:** According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Furthermore, there is no documentation of the patient's intolerance of oral anti-inflammatory medications. Based on the above, Keratek gel with 3 refills is not medically necessary.