

Case Number:	CM14-0106827		
Date Assigned:	07/30/2014	Date of Injury:	02/08/2013
Decision Date:	09/12/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	07/10/2014

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:

This is a 55 year old male with a 2/8/13 date of injury. He sustained a right wrist distal radial fracture and is status post open reduction percutaneous pinning. The patient was seen on 5/27/14, with complaints of persistent pain in the right shoulder and right wrist pain despite conservative measures such as PT, medications, activity restrictions and home exercises. An MRI dated 5/3/14 of the right wrist revealed a 5.7x4.0x5 mm cyst at the navicular bone as well as gouty arthropathy at the radiocarpal joint. Exam findings revealed decreased range of motion and tenderness at the right shoulder and wrist. As well as decreased shoulder and grip strength at 4/5. Treatment to date: Medications, Physical Therapy and Surgery. The UR decision dated 6/16/14 denied the request as use of the medication was considered off label.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topical Medication- Kera-Tek Anagesic gel 4 oz: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Chronic Pain, subsection Medication-Compound Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Page(s): 105.

Decision rationale: A search of online resources revealed that Kera-Tek gel active ingredients include menthol 16%, topical analgesic, and methyl Salicylate 28%, topical analgesic) CA MTUS recommends topical salicylates for temporarily relief of minor aches and pains of muscles and joints associated with single backache, arthritis, strains, bruises and sprains. The patient has significant pain despite his treatment to date, which has included oral medications, surgery, and physical therapy. Kera-Tek is an over the counter topical methyl salicylate and is approved for temporary relief of ached and pains per MTUS. A trial of this medication is reasonable in this case for this patient's wrist and shoulder. Therefore, the request for Kera Tek gel is medically necessary.