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| Case Number: | CM14-0133684 | | |
| Date Assigned: | 08/27/2014 | Date of Injury: | 01/07/2014 |
| Decision Date: | 10/24/2014 | UR Denial Date: | 07/24/2014 |
| Priority: | Standard | Application Received: | 08/20/2014 |

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 31-year-old male with a 1/7/14 date of injury, and left knee ACL reconstruction, synovectomy, chondroplasty, meniscectomy, lysis of adhesions, and manipulation under anesthesia 3/20/14. At the time (7/24/14) of request for authorization for Fluribprofen/Cyclo/Menth Cream 20%/10%/4% x 180 GM and Keratek Gel x 4 oz, there is documentation of subjective left knee pain and stiffness and objective left antalgic gait, mild intra-articular effusion findings. Current diagnoses include status post anterior cruciate ligament reconstruction. Treatment to date includes physical therapy, activity modification, and medications (including Etodolac, Tramadol). Regarding the requested Keratek Gel x 4 oz., there is no documentation of neuropathic pain when trials of antidepressants and anticonvulsants have failed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Keratek Gel x 4 oz: 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.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Within the medical information available for review, there is documentation of diagnosis of status post anterior cruciate ligament reconstruction. However, there is no documentation of neuropathic pain when trials of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for Keratek Gel x 4 oz is not medically necessary.