

<b>Case Number:</b>	CM14-0070043		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	11/06/2010
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	04/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2014

### 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 and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 52- year-old individual was reportedly injured on 11/6/2010. The mechanism of injury was not listed. The most recent progress note, dated 6/26/2014, indicated that there were ongoing complaints of left upper extremity pain. The physical examination demonstrated left shoulder decreased range of motion. Left wrist had decreased range of motion and the patient was unable to make a fist with a 2/5 grip strength. There was also positive tenderness and hypersensitivity to touch as well as decreased sensation at the median and ulnar aspects 4/5. Well-healed surgical scar over the first metacarpal up to the forearm on the lateral aspect was noted. No recent diagnostic studies are available for review. Previous treatment included medications and conservative treatment. A request had been made for Kera Tek Gel and was not certified in the pre-authorization process on 4/22/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kera Tek Gel 4oz:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 OF 127.

**Decision rationale:** MTUS guidelines state that topical analgesics are "largely experimental," and that "any compound product, that contains at least one drug (or drug class), that is not recommended, is not recommended". Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As such, this request is not medically necessary.