

Case Number:	CM14-0077175		
Date Assigned:	07/18/2014	Date of Injury:	11/12/2011
Decision Date:	08/25/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	05/27/2014

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 57-year-old female was reportedly injured on 11/12/2011. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated 2/23/2014 indicated that there were ongoing complaints of neck pain, lower back pain, and right shoulder pain. The physical examination demonstrated cervical spine decreased range of motion and positive tenderness over the paraspinal and trapezius muscles. Right shoulder had decreased range of motion. Shoulder decompression test was positive bilaterally. Strength was decreased 4/5 on the right at C5-C6, C7, and C8. Decreased sensation was noted at C7 and C8, but normal sensation at C5 and C6. Lumbar spine had decreased range of motion with tenderness to the paraspinals equally. Kemp's sign was positive on the right. No recent diagnostic studies were available for review. Previous treatment included previous surgery, physical therapy, medications, and conservative treatment. A request had been made for Kera-Tek Gel 4 ounces and was not medically necessary in the pre-authorization process on 5/16/2014.

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: The Claims Administrator did not cite any medical evidence for its decision.

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

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 considered medically necessary.