

<b>Case Number:</b>	CM14-0087802		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	04/16/2013
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	06/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2014

### 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 Orthopaedic Surgery, 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 37-year-old male warehouse worker sustained an industrial injury on 4/16/13. Injury occurred while he was cleaning a work station and stood up, putting weight on his right knee, resulting in acute buckling and giving way. He underwent right knee arthroscopy with partial medial meniscectomy on 9/20/13. The operative report documented grade IV lateral compartment chondromalacia and partial anterior cruciate ligament tearing that was debrided. The 3/5/14 treating physician report cited persistent frequent grade 8/10 right knee pain. Compensatory grade 4/10 left knee pain was reported. Norco reduced pain from 10/10 to 3/10; naproxen decreased pain from 10/10 to 7/10. Right knee exam documented range of motion 5-110 degrees, medial and lateral joint line tenderness, and quadriceps weakness. There was positive valgus, varus stress testing on the right. McMurray's was positive. An MR arthrogram of the right knee was recommended to rule-out further internal derangement. The treatment plan prescribed Norco and Naproxen. A request for Kera-Tek gel stated that the patient had been intolerant to medications and therapy. Additional physical therapy was requested without a specific rationale or treatment goal. The 6/4/14 utilization review denied the request for Kera-Tek as there was no failure of antidepressants and anticonvulsant medications for neuropathic pain and Norco was reported as beneficial. The request for additional physical therapy was denied as there was no indication as to the functional gains achieved with prior therapy and the number of visits.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kera-Tek Gel 4 oz Apply to affected area 2-3 times daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, page(s) 111-113 Page(s): 111-113.

**Decision rationale:** Under consideration is a request for Kera-Tek gel which is a topical compound containing menthol and methyl salicylate. The California MTUS guidelines state topical medications are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Guideline criteria have not been met. This patient was prescribed oral NSAID and Norco with good documented pain benefit. There is no evidence that first line neuropathic medications have been tried and have failed. There is no compelling reason to support the additional use of a topical agent due to medication intolerance or failure. Therefore, this request for Kera-Tek Gel 4 oz (Apply to affected area 2-3 times daily) is not medically necessary.

**Physical Therapy Right Knee 2X week for 4 Weeks (8 visits):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** California MTUS Post-Surgical Treatment Guidelines do not apply to this case as the 6-month post-surgical treatment period had expired. MTUS Chronic Pain Medical Treatment Guidelines would apply. The MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. Guideline criteria have not been met. There is no clear functional deficit or specific treatment goal documented to be addressed by additional physical therapy. There is no clear documentation of objective measurable functional benefit achieved with prior physical therapy. There is no compelling reason presented to support the medical necessity of supervised physical therapy over an independent home exercise program. Therefore, this request for physical therapy right knee 2 times per week for 4 weeks (8 visits) is not medically necessary.