

Case Number:	CM14-0196699		
Date Assigned:	12/04/2014	Date of Injury:	06/10/2014
Decision Date:	01/22/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/24/2014

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 Rehab, has a subspecialty in Interventional Spine 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:

The patient is a 44 year old male with an injury date on 06/0/2014. Based on the 10/01/2014 progress report provided by the treating physician, the diagnoses are: 1. Right shoulder superior labrum tear with Paralabral cyst 2. Right distal biceps tendonitis. According to this report, the patient complains of right shoulder pain. The pain scale is at a 6/10 and a 7/10 with prolonged working. Examination of the right shoulder reveals a decreased range of motion and positive impingement signs. There was crepitus noted with active and passive range of motion and pain over the subacromial, lateral portion of the shoulder, and over the acromioclavicular articular. The patient's condition is "return to full duty." The treatment plan is MR arthrogram of right shoulder scheduled for 10/02/2014, request authorization for Kera-tek gel-4oz and medications as Motrin and Tylenol NO. 3. The patient's past treatment consist of "therapy, activity restrictions, medications, and home exercises and does remain significantly symptomatic." There were no other significant findings noted on this report. The utilization review denied the request for Kera-tek gel 4 oz. on 11/03/2014 based on the MTUS guidelines. The requesting physician provided treatment reports from 06/20/2014 to 10/28/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kera-Tek Gel 4oz: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: According to the 10/01/2014 report, this patient presents with right shoulder pain. Per this report, the current request is for Kera-tek gel 4 oz. The treating physician mentions the patient has "using Kera-Tek gel twice a day and reports improvement in his pain level from 6/10 to 3-5/10." Kera-tek gel contains methyl salicylate. For salicylate, a topical non-steroidal anti-inflammatory drug (NSAID), MTUS does allow it for peripheral joint arthritis/tendinitis problems. In this case, the patient has improvement with the tropical gel and is diagnosis with tendonitis. The request is medically necessary.