

Case Number:	CM15-0102873		
Date Assigned:	06/05/2015	Date of Injury:	03/21/1983
Decision Date:	07/07/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	05/28/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 injured worker is a 55 year old male, who sustained an industrial injury on March 21, 1983. The injured worker has been treated for low back complaints. The diagnoses have included chronic low back pain, lumbar radiculitis, lumbar herniated nucleus pulposus and lumbar radiculopathy. Treatment to date has included medications, radiological studies, MRI, pain management, epidural steroid injections, a transcutaneous electrical nerve stimulation unit, acupuncture treatments, chiropractic sessions, home exercise program, physical therapy, ice/heat treatments and lumbar surgery. Current documentation dated April 16, 2015 notes that the injured worker reported ongoing low back pain. Examination of the lumbar spine revealed tenderness over the midline and hypertonicity over the paraspinal musculature. Range of motion was limited due to pain. There was a positive straight leg raise test in the right lower extremity. Muscle strength and sensation were noted to be a four/five. The injured workers gait was normal. The treating physician's plan of care included a request for one prescription for Kera-Tek gel for additional pain relief.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription: Kera-Tek gel: 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: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Furthermore, there is no documentation of the patient's intolerance of oral anti-inflammatory medications. Based on the above, the request for Kera-tek Analgesic Gel is not medically necessary.