

<b>Case Number:</b>	CM15-0195819		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	01/22/2015
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	09/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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, New York  
 Certification(s)/Specialty: Family Practice

### 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 61 year old male, who sustained an industrial injury on 1-22-2015. He reported a low back injury from lifting activity. The MRI dated 4-8-15, revealed "a partially sacralized L5, disc degeneration and paravertebral spondylosis, L4-L5 small central disc extrusion with right foraminal stenosis." Diagnoses include lumbar disc herniation with radicular symptoms. Treatments to date include activity modification, anti-inflammatory, and physical therapy. On 4-15-15, the provider documented ongoing low back pain with radiation down the right leg. "He has disc herniation at L4-L5 with stenosis at right L5 neural foramina. This is likely the source of the patient's pain. He has failed to improve with conservative management" and referred to pain management for possible epidural injection. The records did not indicate he underwent epidural injections. On 7-30-15, he complained of ongoing low back pain with radiation down bilateral lower extremities, right greater than left. Pain was rated at worst an 8-9 out of 10 VAS. The physical examination documented decreased lumbar range of motion, tenderness, hypertonicity, and a positive right side straight leg raise test. There was decreased sensation to L5-S1 nerve distributions on the right lower extremity. The plan of care included spinal surgeon consultation, EMG and nerve conduction studies, Kera-Tek and Tylenol #3. The appeal requested authorization for a spine surgeon consultation and a prescription for Kera-Tek Gal 4 ounces. The Utilization Review dated 9-11-15, denied this request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Consultation with spine surgeon:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations, General Approach.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** The request is considered not medically necessary. The patient was documented to have pain radiating to his right lower extremity, but no significant physical exam findings. According to MTUS guidelines, a referral is indicated for patients with persistent and severe symptoms, activity limitation for more than one month or extreme progression of symptoms, clear clinical, imaging, and electrophysiologic evidence, consistently indicating same lesion, or unresolved radicular symptoms after receiving conservative treatment. There is not enough evidence of decreased function due to the injury or evidence of a lesion that would benefit from surgery. The patient's physical exam does not warrant a neurosurgical consult. If the treatment plan includes an epidural, the patient may benefit from a pain management consult. Therefore, the request is considered not medically necessary.

**Kera-Tek gel 4oz, prescription:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Salicylate topicals, Topical Analgesics.

**Decision rationale:** The request for kera-tek gel is not medically necessary. According to MTUS guidelines, any compounded product that contains at least one drug that is not recommended is not recommended. Methyl salicylate may be useful for chronic pain. However, there are no guidelines for the use of menthol with the patient's spine complaints. He is not documented to have failed all oral analgesics. Therefore, the request is considered not medically necessary.