

<b>Case Number:</b>	CM14-0154056		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	02/17/2011
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	09/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2014

### 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 Occupational Medicine 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:

According to the records made available for review, this is a 49-year-old male with a 2/17/11 date of injury, and status post anterior and posterior fusion L3-S1. At the time (9/9/14) of request for authorization for 1 Pain Management Consultation, and 1 prescription of Kera-Tek analgesic gel, there is documentation of subjective (pain rated 7/100, pain radiating to the left lower extremity) and objective (very limited range of motion because of pain, asymmetric loss of range of motion, tenderness over the midline and tenderness over the paraspinals, positive straight leg raise in the lower extremities) findings, current diagnoses (status post L3-S1 anterior and posterior fusion with residual right leg radicular pain, MRI evidence of persistent right-sided foraminal and subarticular stenosis at L4-5 and L5-S1), and treatment to date (physical therapy, chiropractic, home exercise, electric muscle stimulation, acupuncture, medications (ibuprofen, Valium, and Norco), activity modification, aqua therapy, and epidural steroid injection). 8/22/14 medical report identifies a request for pain management to take over management of all the patient's medications. In addition, 8/22/14 medical report identifies a request to continue treatment with pain management for injection and medications. Regarding the requested 1 Pain Management Consultation, there is no documentation of a rationale for an additional Pain Management consultation. Regarding the requested 1 prescription of Kera-Tek analgesic gel, there is no documentation that trials of antidepressants and anticonvulsants have failed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Pain Management Consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment, 4/27/2007, pg. 56

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and consultations, page(s) 127

**Decision rationale:** MTUS reference to ACOEM guidelines identifies that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work, as criteria necessary to support the medical necessity to support the medical necessity of consultation. Within the medical information available for review, there is documentation of diagnoses of status post L3-S1 anterior and posterior fusion with residual right leg radicular pain, MRI evidence of persistent right-sided foraminal and subarticular stenosis at L4-5 and L5-S1. In addition, there is documentation that consultation is indicated to aid in the therapeutic management. However, given documentation that the patient is already under the care of Pain Management [REDACTED] there is no documentation of a rationale for an additional Pain Management consultation. Therefore, based on guidelines and a review of the evidence, the request for 1 Pain Management Consultation is not medically necessary.

**1 prescription of Kera-Tek analgesic gel:** 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 Topical Analgesics, Page(s): 111.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Within the medical information available for review, there is documentation of diagnoses of status post L3-S1 anterior and posterior fusion with residual right leg radicular pain, MRI evidence of persistent right-sided foraminal and subarticular stenosis at L4-5 and L5-S1. In addition, there is documentation of neuropathic pain. However, there is no documentation that trials of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for 1 prescription of Kera-Tek analgesic gel is not medically necessary.