

Case Number:	CM15-0093767		
Date Assigned:	05/19/2015	Date of Injury:	05/12/2014
Decision Date:	06/22/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	04/15/2015

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: California

Certification(s)/Specialty: Emergency 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 38-year-old male who sustained an industrial injury on May 12, 2014. He has reported injury to the back radiating to the leg and has been diagnosed with clinical and MRI scan evidence of a severe disc herniation of the lumbar spine at the L5-S1 level. Examination of the thoracolumbar spine revealed a normal posture with loss of lordosis. Forward flexion was accomplished to 60 degrees; with the fingertips, failing to touch the toes by 20 cm. Reversal of the lumbar lordosis was full. Arising was accomplished with difficulty and pain. Lateral bending and extension were decreased. Palpation of the lumbar spine revealed tenderness with tightness and spasm. Leg lengths and circumference were equal bilaterally. Supine and active straight leg raising were positive at 60 degrees on the right. Motor and sensory examinations were slightly decreased. The treatment request included medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine 50mg/Caffeine 10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The requested Orphenadrine 50mg/Caffeine 10mg #60, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants, Page 63-66, do not recommend muscle relaxants as more efficacious than NSAIDs and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has pain to the back radiating to the leg and has been diagnosed with clinical and MRI scan evidence of a severe disc herniation of the lumbar spine at the L5-S1 level. Examination of the thoracolumbar spine revealed a normal posture with loss of lordosis. Forward flexion was accomplished to 60 degrees; with the fingertips, failing to touch the toes by 20 cm. Reversal of the lumbar lordosis was full. Arising was accomplished with difficulty and pain. Lateral bending and extension were decreased. Palpation of the lumbar spine revealed tenderness with tightness and spasm. Leg lengths and circumference were equal bilaterally. Supine and active straight leg raising were positive at 60 degrees on the right. Motor and sensory examinations were slightly decreased. The treating physician has not documented duration of treatment, intolerance to NSAID treatment, nor objective evidence of derived functional improvement from its previous use. The criteria noted above not having been met, Orphenadrine 50mg/Caffeine 10mg #60 is not medically necessary.

KeraTek gel 4oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: The requested KeraTek gel 4oz is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has pain to the back radiating to the leg and has been diagnosed with clinical and MRI scan evidence of a severe disc herniation of the lumbar spine at the L5-S1 level. Examination of the thoracolumbar spine revealed a normal posture with loss of lordosis. Forward flexion was accomplished to 60 degrees; with the fingertips, failing to touch the toes by 20 cm. Reversal of the lumbar lordosis was full. Arising was accomplished with difficulty and pain. Lateral bending and extension were decreased. Palpation of the lumbar spine revealed tenderness with tightness and spasm. Leg lengths and circumference were equal bilaterally. Supine and active straight leg raising were positive at 60 degrees on the right. Motor and sensory examinations were slightly decreased. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, KeraTek gel 4oz is not medically necessary.

