

<b>Case Number:</b>	CM14-0108771		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	09/21/2006
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	06/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2014

### 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 & Rehabilitation, Pain Medicine and is licensed to practice in Ohio and Texas. 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 injured worker is a 40-year-old male who reported injury on 09/12/2006. The mechanism of injury was not documented in the submitted report. The injured worker has diagnoses of myofascial pain and lumbosacral/thoracic neuritis. The injured worker's past treatment consists of the use of a TENS unit, physical therapy, and medication therapy. Medications include tramadol/APAP 37.5/325, omeprazole 20 mg, naproxen sodium 550 mg, and Methoderm lotion. The duration and frequency were not submitted in the documentation. No pertinent diagnostics on the injured worker were submitted for review. The injured worker has postop lumbar surgery 2007. The injured worker complained of low back pain that radiated to bilateral lower extremities, the right greater than the left. The injured worker rated her pain at a 4/10. Physical examination dated 06/14/2014 showed that the injured worker was tender to palpation on the lumbar spine, with spasm. The submitted report lacked any evidence of range of motion or motor strengths. The treatment plan is for the injured worker to continue the use of Methoderm 120 ml. The rationale was not submitted for review. The Request for Authorization form was submitted on 10/26/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trial of Methoderm 120 ml:** 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:** The request for Methoderm 120 ml is not medically necessary. The injured worker complained of low back pain that radiated to bilateral lower extremities, the right greater than the left. The injured worker rated her pain at a 4/10. The MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety; also, that they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control; however, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended, therefore, is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Methoderm consists of methyl salicylate 15% analgesic/counter adherent and menthol 10% analgesic/counter adherent. Given the above, Methoderm is not recommended by the MTUS. Furthermore, there is no literature to support efficacy, and advantage over over-the-counter medication or other medications already being prescribed. There was also no evidence of antidepressants and anticonvulsants having been tried and failed. The submitted request also did not specify a dosage, duration, or frequency of the medication. As such, the request for Methoderm 120 mL is not medically necessary.