

<b>Case Number:</b>	CM14-0168198		
<b>Date Assigned:</b>	10/15/2014	<b>Date of Injury:</b>	09/01/2011
<b>Decision Date:</b>	11/18/2014	<b>UR Denial Date:</b>	10/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2014

### 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 Family 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:

This is a 65year old male patient who sustained a work related injury on 9/1/11. Patient sustained the injury due to lifting. The current diagnosis includes lumbar herniated disc with radiculopathy. Per the doctor's note dated 9/24/14, patient has complaints of low back pain at 8/10 which was radiating to both legs. Physical examination revealed tenderness on palpation, decreased range of motion, positive Kemp's test and straight raising test, decreased sensation at L5 on right side, 5/5 strength and no motor weakness. The medication lists include Tramadol and Motrin. The patient has had MRI of the lumbar spine on 4/25/14 that revealed disc protrusion with foraminal narrowing and central canal stenosis. He has had a urine drug toxicology report on 4/4/13. The patient has received an unspecified number of PT visits for this injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kera-tek analgesic 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): 111-112.

**Decision rationale:** Kera-tek analgesic gel contains menthol and methyl salicylate gel. According to the MTUS Chronic Pain Guidelines regarding topical analgesics state that the use of topical analgesics is "Largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed.... 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 is not recommended... Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI (serotonin-norepinephrine reuptake inhibitor) anti-depressants or an AED (antiepilepsy drug such as gabapentin or Lyrica). Non-neuropathic pain: Not recommended.... Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments....." MTUS guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. Any trial of antidepressants and anticonvulsants for these symptoms are not specified in the records provided. Any intolerance or contraindication to oral medications is not specified in the records provided. Any evidence of lack of response or intolerance to other treatments was not specified in the records provided. In addition, as cited above, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is also no evidence that menthol is recommended by the CA MTUS, Chronic pain treatment guidelines. The medical necessity of Kera-tek analgesic gel is not fully established in this patient.

**Lumbar support:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Chapter:Low Back (updated 10/28/14) Lumbar supports

**Decision rationale:** Per the ACOEM guidelines cited below "There is no evidence for the effectiveness of lumbar supports in preventing back pain in industry." In addition per the ODG cited below regarding lumbar supports/brace, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain..... Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain (LBP) (very low-quality evidence, but may be a conservative option). Under study for post-operative use; see Back brace, post operative (fusion)." The patient has received an unspecified number of PT visits for this injury. Response to prior conservative therapy was not specified in the records provided. Prior conservative therapy notes were not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. There is no evidence of instability, spondylolisthesis, lumbar fracture or recent lumbar surgery. The medical necessity, of Lumbar support is not fully established.

