

<b>Case Number:</b>	CM14-0168768		
<b>Date Assigned:</b>	10/17/2014	<b>Date of Injury:</b>	04/14/2014
<b>Decision Date:</b>	11/18/2014	<b>UR Denial Date:</b>	10/03/2014
<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 Physical Medicine and Rehabilitation and is licensed to practice in 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:

Medical records reflect the claimant is a 69 year old female who sustained a work injury on 4-14-14. Office visit on 9-26-14 notes the claimant has persistent low back pain with radiation to her right thigh with numbness. The claimant also has right shoulder pain. The pain is controlled with rest and medications. On exam, the claimant has decreased range of motion, tenderness to palpation, and decreased sensation at 4/5 at L4 only on the right. She has significant range of motion loss at the shoulder with tenderness at the AC joint. There was 1+ swelling at the subscapular region. The claimant has positive Empty can test. The claimant has decreased strength 4/5 with flexion and abduction. EMG/NCS dated 7-18-14 in the lower extremities was normal.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Keratek Analgesic Gel, 4oz,:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals Page(s): 105.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER - TOPICAL ANALGESICS

**Decision rationale:** Chronic Pain Medical Treatment Guidelines notes that topical analgesics are 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 an absence in documentation noting that this claimant failed first line of treatment or that she cannot tolerate the oral medications. Therefore, the medical necessity of this request was not established.

**Lidoderm Patches, 5%,:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56-57.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM PATCHES Page(s): 56-57. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER - LIDODERM PATCHES

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG, this medication is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. This claimant has a normal EMG/NCS. There is no evidence of radiculopathy. Therefore, the medical necessity of this request is not established.