

Case Number:	CM15-0120097		
Date Assigned:	06/30/2015	Date of Injury:	06/02/2012
Decision Date:	08/04/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	06/22/2015

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: Florida

Certification(s)/Specialty: Neurology, Pain Management

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 58 year old female, who sustained an industrial injury on 6/2/2012. Diagnoses have included lumbar spine spondylolisthesis at L4/L5, chronic cervical sprain/strain, lumbar disc herniation, right shoulder rotator cuff syndrome, bilateral lower extremity radiculopathy and insomnia, anxiety and acute depression, ongoing. Treatment to date has included acupuncture, physical therapy, an epidural injection and medication. According to the progress report dated 5/19/2015, the injured worker complained of lower back and left shoulder pain. She rated the lower back pain as 8/10 with radiation of pain down both legs. She rated the left shoulder pain as 7/10. The pain was made better with rest and medication. She ambulated with a cane. Exam of the cervical spine and lumbar spine revealed loss of motion. There was palpable muscular hypertonicity and tenderness in the bilateral upper trapezius and lumbar paravertebral muscles. Authorization was requested for a prescription for Kera-Tek analgesic gel (methyl salicylate/menthol), 4oz.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription for Kera-Tek analgesic gel (methyl salicylate/menthol), 4 oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical medications, Salicylate topicals.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

Decision rationale: The medical records provided for review do not indicate a neuropathic pain condition with associated hyperalgesia/allodynia. The records do not report poor tolerance to oral medications or indicate any specific medications failed, specifically trials of antidepressants and anticonvulsants. MTUS supports this agent is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As the records do not indicate specific antidepressants and anticonvulsants tried and failed, the medical records do not support use of Kera-Tek analgesic gel congruent with MTUS.