

<b>Case Number:</b>	CM14-0105110		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	02/16/2014
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2014

### 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 and Pain Medicine and is licensed to practice in Texas and Ohio. 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 30-year-old male who reported an injury on 02/16/2014. The mechanism of injury was not provided. The documentation of 05/14/2014 revealed the injured worker had physical therapy. The injured worker had increased pain with repetitive motion. The injured worker had decreased pain with rest and pain medications. The injured worker had pain to the cervical spine and thoracic spine. The injured worker had a positive empty can test in the bilateral upper extremities. The diagnoses included thoracic spine and cervical spine sprain and strain and right shoulder sprain and strain. The physical examination was difficult to read as it was handwritten. The treatment plan included an MRI for the cervical spine, lumbar spine, and thoracic spine and an MR arthrogram for the right shoulder. Additionally, the treatment plan included physical therapy 2 times 4 weeks, a psychological evaluation, and Mentoderm, cyclobenzaprine, naproxen, hydrocodone/APAP, and omeprazole.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Mentoderm 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, Topical Salicylates Page(s): 105, 1111.

**Decision rationale:** The California MTUS guidelines indicate 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. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. They further indicate that topical salicylates are appropriate for the treatment of pain. The clinical documentation submitted for review failed to indicate the injured worker had a trial of antidepressants and anticonvulsants that had failed. There was a lack of documentation indicating a necessity for a topical gel. The duration of use could not be established. The request for Methoderm gel failed to indicate the frequency, quantity, and strength for the requested medication. Given the above, the request for Methoderm Gel is not medically necessary.