

<b>Case Number:</b>	CM14-0127233		
<b>Date Assigned:</b>	08/15/2014	<b>Date of Injury:</b>	04/17/2013
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	07/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/11/2014

### 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 Anesthesia, has a subspecialty in Pain Medicine and Acupuncture 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:

The 29 year old male injured has a date of injury of 4/17/13 with related bilateral hand pain. Per progress report dated 5/28/14, the injured worker also complained of swelling and weakness. He was status post open reduction/internal fixation third metacarpal fracture. He also had low back pain radiating down both legs, worse on the left. He also complained of bilateral knee pain and neck pain. He stated he had right hip pain and headaches as well. Per physical exam he had diminished sensation and paresthesias on the left. His right wrist was tender to palpation. He had tender lumbar paraspinals. EMG studies of the cervical spine and upper extremities showed no acute or chronic denervation potentials in any of the muscles tested. MRI of the lumbar spine revealed disc bulges at two levels, and mild central canal stenosis. Treatment to date has included physical therapy and medication management. The date of UR decision was 7/29/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Unknown Mentherm creams:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications: and Salicylate Topicals.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** Menthoderm is methyl salicylate and menthol. Methyl salicylate may have an indication for chronic pain in this context. Per MTUS p105, "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004)." However, the CA MTUS, ODG, National Guidelines Clearinghouse, and ACOEM provide no evidence-based recommendations regarding the topical application of menthol. It is the opinion of this IMR reviewer that a lack of endorsement, a lack of mention, inherently implies a lack of recommendation, or a status equivalent to "not recommended". Since menthol is not medically indicated, then the overall product is not indicated per MTUS as outlined below. Note the statement on page 111: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Regarding the use of multiple medications, MTUS p60 states "Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Men's, 2005) The recent AHRQ review of comparative effectiveness and safety of analgesics for osteoarthritis concluded that each of the analgesics was associated with a unique set of benefits and risks, and no currently available analgesic was identified as offering a clear overall advantage compared with the others." Therefore, this request is not considered medically necessary.

**1 ROM testing:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Flexibility.

**Decision rationale:** The MTUS is silent on the use of range of motion testing. The ODG TWC redirects to flexibility testing, regarding which, it states: "Not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent." This request is not medically necessary

**Functional Capacity Evaluation:**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21-22.

**Decision rationale:** The ACOEM Guidelines in regard to FCE detailed the recommendation for consideration of a Functional Capacity Evaluation when necessary to translate medical impairment into functional limitations to determine work capability. The ODG details the

recommendation to consider a FCE if the patient has evidence of prior unsuccessful return to work attempts or there is conflicting medical reporting on precautions and/or fitness for a modified job or if the patient's injuries are such that require detailed exploration of the worker's abilities. The documentation submitted for review fails to indicate if the injured worker has had prior unsuccessful return to work attempts, that the injured worker requires a modification for return to work, or that the injured worker has additional injuries which require detailed exploration of the employee's abilities. These are the criteria set forth by the ODG for the consideration of an FCE. The request is considered not medically necessary.