MAXIMUS Federal Services

Case Number:	CM14-0134117		
Date Assigned:	09/15/2014	Date of Injury:	05/01/2013
Decision Date:	10/15/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/22/2014

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 Internal Medicine, has a subspecialty in Pulmonary Disease 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 injured worker is a 38-year-old male who reported injuries on 03/25/2007 and 08/06/2013 due to cumulative trauma injury to the neck, right shoulder, and bilateral wrists. The diagnoses of cervical myofascial pain, impingement syndrome to the right shoulder, Erb's palsy, left upper extremity nonindustrial, carpal tunnel syndrome right wrist, and cubital tunnel syndrome to the right elbow. The injured worker had an MRI dated 05/21/2014 of the left wrist that revealed subacromial cyst formation within the triquetrum. Medications included Menthoderm, LenzaPatch, Cyclobenzaprine, Naproxen, Hydrocodone, and Omeprazole, Quazepam, and Tramadol. The past treatments included acupuncture, medication, and electric shock. The physical examination to the cervical spine revealed flexion of 90 and extension of 60 degrees with sensation and 2 point discrimination is discriminated at 8 mm in all digits. Deep tendon reflexes were 2+. The treatment plan included refill for the Menthoderm. The request for authorization was not submitted within the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

MENTHODERM (METHYL SALICYLATE 15%/MENTHOL 10%) GEL, 360GM DOS 6/4/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, PAIN (CHRONIC)

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

Decision rationale: The California MTUS Guidelines state that topical components are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants ant anticonvulsants have failed. Additionally, any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines state that capsaicin is recommended only as an option in injured workers who have not responded to or are tolerant to other treatments. The guidelines indicated that if 1 component is not recommended; therefore, it is not recommended. The request did not indicate the frequency or the dosage. As such, the request is not medically necessary.