

<b>Case Number:</b>	CM14-0151794		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	10/20/2000
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	09/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 42-year-old male with a 10/20/00 date of injury. At the time (8/25/14) of request for authorization for Menthoderm cream 120gms and Unknown Continuation of Orthopedic treatment, there is documentation of subjective complaints include mid back, neck, and left shoulder pain; low back pain radiating to right hip, anterior lateral knee, and thigh with numbness and burning; and occipital headache. Objective findings include tenderness to palpation over paracervical, paralumbar, and parathoracic muscle; decreased sensation in hands, right outer leg, and anterior lateral foot to light touch; and decreased range of motion to left shoulder. Imaging findings include reported MRI arthrogram of left shoulder (12/6/12) revealed tearing of anterior superior and superior labrum; moderate tear near the supraspinatous and infraspinatous tendon; and severe atrophic minor tendonitis of subscapularis tendon; report not available for review. Current diagnoses include thoracic strain, lumbar radiculopathy, cervical strain, right hip strain, and status post left shoulder surgery. Treatments to date include physical therapy and medications, including ongoing treatment with Lidoderm patch and Menthoderm creams. Medical reports identify that Menthoderm cream has been helpful for better pain control and improved activities of daily living, and that the patient is intolerant to any oral pain or relevant medication to manage chronic symptomatology. In addition, medical report identifies a request to continue orthopedic care for shoulder pain for some therapy. Regarding Menthoderm cream, there is no documentation that trials of antidepressants and anticonvulsants have failed. Regarding Unknown Continuation of Orthopedic treatment, there is no documentation of the medical necessity for a follow-up visit in order to monitor the patient's progress and make any necessary modifications to the treatment plan.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Menthoderm cream 120gms:** 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 Page(s): 111-112. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20 Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/cdi/menthoder-cream.html>

**Decision rationale:** Medical Treatment Guideline identifies Menthoder cream as a topical analgesic containing Methyl Salicylate and Menthol. MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when trial of antidepressants and anticonvulsants have failed, as criteria necessary to support the medical necessity of topical analgesics. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of thoracic strain, lumbar radiculopathy, cervical strain, right hip strain, and status post left shoulder surgery. In addition, there is documentation of neuropathic pain and ongoing treatment with Menthoder cream. Furthermore, given documentation that Menthoder helps improve activities of daily living, there is documentation of functional benefit and increase in activity tolerance as a result of Menthoder cream use to date. However, there is no documentation that a trial of antidepressants and anticonvulsants has failed. Therefore, based on guidelines and a review of the evidence, the request for Menthoder cream 120gms is not medically necessary.

**Unknown Continuation of Orthopedic treatment:** 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127; Official Disability Guidelines (ODG) Pain Chapter, Office visits

**Decision rationale:** MTUS reference to ACOEM guidelines state that the occupational health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial facts are present, or when the plan or course of care may benefit from additional expertise. Official Disability Guidelines (ODG) identifies that office visits are based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Within the medical information available for review, there is documentation of

diagnoses of thoracic strain, lumbar radiculopathy, cervical strain, right hip strain, and status post left shoulder surgery. However, despite documentation of a request to continue orthopedic care for shoulder pain for some therapy, and given no documentation of the specific therapy being requested, there is no documentation of the medical necessity for a follow-up visit. Therefore, based on guidelines and a review of the evidence, the request for unknown continuation of orthopedic treatment is not medically necessary.