

Case Number:	CM14-0153040		
Date Assigned:	09/23/2014	Date of Injury:	04/10/2007
Decision Date:	10/24/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/19/2014

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 and Rehabilitation and is licensed to practice in Illinois. 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 43-year-old female who reported injury on 04/10/2007. The mechanism of injury was not submitted for review. The injured worker has diagnoses of chronic low back pain, chronic compression fractures, left shoulder arthralgia, cervical disc herniations with neural foraminal narrowing and cp. The injured worker has past medical treatment of surgery, ESIs, physical therapy, acupuncture, and medication therapy. Medications consist of Prilosec, Norco, docuprene, Lidopro cream, ibuprofen, omeprazole, hydrocodone, and Methoderm gel. An MRI of the cervical spine dated 01/04/2011 revealed cervical musculature spasm; mild spondylosis at C4-5, C5-6, and C6-7. On 08/07/2014, the injured worker complained of back and neck pain. Physical examination noted that the pain rate was 6/10 to 7/10. It was also noted in physical exam that the injured worker was tender to palpation at the cervical paravertebral musculature, right greater than left, associated with spasm. Range of motion of the cervical and lumbar spines were decreased in all planes and limited by pain. There was a decreased sensation at C5-6 dermatomes on the left. Spurling's test on the left was positive for radiating symptoms to the left upper extremity. Lower extremity sensation was intact. Medical treatment plan was for the injured worker to continue the use of medication therapy. Rationale was not submitted for review. The Request for Authorization form was submitted on 01/14/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for menthoderm gel 4oz #1: 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.

Decision rationale: The request for Methoderm gel is not medically necessary. California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. Also, they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control; however, there is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Methoderm consists of methyl salicylate 15% and menthol 10%. Guidelines also stipulate that there is no literature to support efficacy, and advantage over the counter medication or other medications already being prescribed. The submitted documentation did not indicate the efficacy of the medication. Additionally, there was no evidence of antidepressants and anticonvulsants having been tried and failed. The request as submitted did not specify a duration or frequency of the medication, nor did it mention the location as to where the medication would be applied. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.