

<b>Case Number:</b>	CM14-0158397		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	03/13/1998
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	09/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2014

### 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 Family Medicine and is licensed to practice in North Carolina. 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 patient is a 59-year-old with a reported date of injury of 03/13/1998. The patient has the diagnoses of T8 burst fracture, T7 burst fracture, and T12 burst fracture, status post lumbar fusion, pseudoarthrosis L4/5, lumbar degenerative disc disease, lumbar radiculopathy, left knee internal derangement and chronic pain syndrome. Per the most recent progress reports provided for review by the primary treating physician dated 09/02/2014, the patient had complaints of continued neck and back pain and leg weakness. The physical exam noted antalgic gait tenderness to palpation over T12 and T7 and decreased strength in the upper and lower extremities. Treatment plan recommendations included continuation of medications, bone scan and pain management.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Menthoderm gel 4oz:** Upheld

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

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

**Decision rationale:** The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. 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. (Namaka, 2004) 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. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication is not listed as a recommended topical analgesic per the California MTUS. In the absence of recommendation the request cannot be considered medically necessary as it does not meet guideline criteria for topical analgesic use.