

Case Number:	CM14-0030613		
Date Assigned:	06/20/2014	Date of Injury:	06/15/1998
Decision Date:	07/17/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/10/2014

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 & 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 42 year old female who reported an injury on 06/15/1998 due to unknown mechanism. The injured worker reports constant lower back pain and left hip. The progress note dated 02/20/2014 revealed cervical range of motion of forward flexion to 70%, extension to 80%, lateral flexion right to 80%, lateral flexion left to 70%, rotation right to 75%, and rotation left to 75%. Examination of lower extremities revealed positive Fabere left and right causing low back pain. Right straight leg raising test producing low back pain at 55 degrees, bilateral leg raising test producing low back pain. Pinwheel testing revealed hypoesthesia over the right S1 dermatome. Diagnostic studies were not submitted with the document. Medications reported were naproxen, Norco, HCTZ, Prilosec. The treatment plan was recommendation of spinal cord stimulator trial, continue medications as prescribed and use menthoderm topical cream. The rationale and request for authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Menthoderm DOS 1/23/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 112.

Decision rationale: The request for menthoderm is non-certified. California Medical Treatment Utilization Schedule states that topical analgesics are 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. It also states any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The injured worker does not have any other medications reported that she has tried and failed. Also there is no documentation of physical therapy having been completed or initiated. Diagnostic studies were not submitted. Therefore, the request is non-certified.