

Case Number:	CM14-0066949		
Date Assigned:	07/11/2014	Date of Injury:	06/08/2000
Decision Date:	08/18/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/12/2014

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 Preventive Medicine, has 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 63-year-old female with a 6/8/00 date of injury. At the time (4/28/14) of the request for authorization for Menthoderm Gel 120 gm, there is documentation of subjective (low back pain with radiation to the lower extremity, right greater than left numbness and tingling) and objective (antalgic gait, decreased lumbar range of motion, paraspinal muscles spasms, right lower extremity decreased sensation) findings, current diagnoses (lumbar region injury status post surgery, right sided lumbar radiculopathy, post operative chronic pain, gastritis without hemorrhage, myofascial pain/right knee meniscal tear, and poor coping with chronic pain), and treatment to date (medication). There is no documentation that trial of antidepressants and anticonvulsants have failed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Menthoderm Gel 120 gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111 of 127.

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: <http://www.drugs.com/cdi/menthoder-cream.html>.

Decision rationale: The Medical Treatment Guideline identifies Mentherm cream as a topical analgesic containing Methyl Salicylate and Menthol. The 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. Within the medical information available for review, there is documentation of diagnoses of lumbar region injury status post surgery, right sided lumbar radiculopathy, postoperative chronic pain, gastritis without hemorrhage, myofascial pain/right knee meniscal tear, and poor coping with chronic pain. In addition, there is documentation of neuropathic pain. However, there is no documentation that trial of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for Mentherm Gel 120 gm is not medically necessary.