

<b>Case Number:</b>	CM14-0177024		
<b>Date Assigned:</b>	10/30/2014	<b>Date of Injury:</b>	03/15/2011
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	09/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 46 year old male, who sustained an industrial injury on 3/15/2011. Diagnoses include status post posterior fusion L5-S1. Treatment to date has included surgical intervention, walker, pain management specialist, aquatic therapy, physical therapy and medications. He underwent a posterior instrumentation and fusion at L5-S1 (10/10/2013). Per the Primary Treating Physician's Progress Report dated 4/15/2014, the injured worker reported low back pain rated as 8/10 with radiation to the buttocks and bilateral lower extremities. Physical examination revealed decreased range of motion and tenderness to palpation of the lumbar paraspinal muscles. He is assisted with a walker. The plan of care included pain medications and continuation of home exercise program. Authorization was requested for refill of Methoderm creams.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methoderm cream refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Mentoderm contains methyl salicylate 15% and menthol 10%. According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended. Mentoderm (menthol and methyl salicylate) contains menthol a topical analgesic that is not recommended by MTUS. Furthermore, there is no documentation of the patient's intolerance of oral anti-inflammatory medications. Based on the above, Mentoderm is not medically necessary.