

Case Number:	CM14-0204542		
Date Assigned:	12/16/2014	Date of Injury:	06/18/2013
Decision Date:	02/05/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	12/08/2014

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 Emergency Medicine, 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:

The injured worker is a 30 year-old female, who sustained an injury on June 18, 2013. The mechanism of injury is not noted. Diagnostics have included: cervical spine MRI dated November 21, 2013 reported as showing C6-7 disc dessication and herniation. Treatments have included: acupuncture, medications, physical therapy, injections, shockwave therapy. The current diagnoses are: cervical strain, right shoulder strain, lumbar strain and disc herniations. The stated purpose of the request for Menthoderm Ointment 120ml was not noted. The request for Menthoderm Ointment 120ml was denied on November 12, 2014, citing a lack of documentation of guideline support. The stated purpose of the request for Physical Therapy 2 times a week for 4 weeks for the cervical, lumbar spine, right knee, and right shoulder was not noted. The request for Physical Therapy 2 times a week for 4 weeks for the cervical, lumbar spine, right knee, and right shoulder was denied on November 12, 2014, citing a lack of documentation of functional improvement. Per the report dated October 20, 2014, the treating physician noted complaints of pain to the neck, back, right knee and right ankle. Exam showed right knee medial joint line tenderness, cervical and lumbar tenderness and restricted range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Menthoderm Ointment 120 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Chapter, Alicylate topicals; <http://www.drugs.com/cdi/menthoderm-cream.html>

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

Decision rationale: The requested Menthoderm Ointment 120 ml, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, pages 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has pain to the neck, back, right knee and right ankle. The treating physician has documented right knee medial joint line tenderness, cervical and lumbar tenderness and restricted range of motion. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, Menthoderm Ointment 120 ml is not medically necessary.

Physical Therapy 2 times a week for 4 weeks for the cervical, lumbar spine, right knee, and right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy.

Decision rationale: The requested Physical Therapy 2 times a week for 4 weeks for the cervical, lumbar spine, right knee, and right shoulder, is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 8, Neck and Upper Back Complaints, Summary of Recommendations and Evidence, page 181; and Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy, recommend continued physical therapy with documented objective evidence of derived functional benefit. The injured worker has pain to the neck, back, right knee and right ankle. The treating physician has documented right knee medial joint line tenderness, cervical and lumbar tenderness and restricted range of motion. The treating physician has not documented sufficient objective evidence of derived functional benefit from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical Therapy 2 times a week for 4 weeks for the cervical, lumbar spine, right knee, and right shoulder is not medically necessary.

