

<b>Case Number:</b>	CM15-0003648		
<b>Date Assigned:</b>	01/16/2015	<b>Date of Injury:</b>	02/27/2013
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	12/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2015

### 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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 27-year-old female who reported an injury on 02/27/2013 after a slip and fall. The injured worker reportedly sustained an injury to her right shoulder and right lower back. The injured worker's treatment history included physical therapy, multiple medications, and injections. The injured worker was evaluated by a Qualified Medical Examiner on 09/22/2014. The physical findings at that appointment included tenderness to palpation over the posterior and superior right shoulder. The injured worker had limited lumbar range of motion and tenderness to palpation over the right lumbar spine. The injured worker's diagnoses included rotator cuff syndrome, lumbago, depression, and insomnia. The clinical note for the retrospective date 11/05/2014 was not provided. A Request for Authorization form was not submitted to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Menthoderm Cream #2 (DOS:11.5.14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals and Topical Analgesics Page(s): 106 and 111.

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

**Decision rationale:** The retrospective request for Mentherm cream #2 (DOS: 11/05/2014) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends topical analgesics after the patient has failed first line medications such as antidepressants and anticonvulsants. The clinical documentation submitted for review does not provide any evidence that the injured worker had failed to respond to these types of medications as of 11/05/2014. Additionally, there is no record submitted for review from 11/05/2014 to indicate that the injured worker has deficits that require the use of topical analgesics. As such, the retrospective Mentherm cream #2 (DOS: 11/05/2014) is not medically necessary or appropriate.