

<b>Case Number:</b>	CM15-0103837		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	07/15/2014
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

This 49-year-old male sustained an industrial injury on 7/15/14. He subsequently reported left hand, back and left leg pain. Diagnoses include contusions of the left foot and left hand, internal derangement of the left knee with chondromalacia patella and dorsal lumbosacral strain and sprain. Treatments to date include x-ray testing, use of a knee and wrist brace and prescription pain medications. The injured worker continues to experience pain in the low back, left hand, left knee and left foot. Upon examination, there was antalgic gait in the left lower extremity noted. Tenderness was noted in the left wrist, along the left knee medial joint line and the distal aspect of the metatarsal joint of the left foot. McMurray's test was negative, there was retropatellar crepitus noted. The treating physician made a request for Menthoderm cream, Flexeril, 24 chiropractic visits for the left knee and lumbar spine, MRI of the lumbar spine and left knee and x-ray of the lumbar spine and left knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Menthoderm cream 240mg #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 111-113.

**Decision rationale:** Menthoderam Cream is a topical analgesic containing Methyl Salicylate 15.00% and Menthol 10.00%. According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. There is no peer-reviewed literature to support the use of topical Menthoderam Cream. Menthoderam cream 240mg #1 is not medically necessary.

**Flexeril 10mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Antispasmodics, Cyclobenzaprine (Flexeril).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 64.

**Decision rationale:** The Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants. There is no documented functional improvement from any previous use in this patient. The MTUS also state that muscle relaxants are no more effective than NSAID's alone. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. Flexeril 10mg #60 is not medically necessary.

**24 chiropractic visits for the left knee and lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 58-60.

**Decision rationale:** The request is for 24 visits of chiropractic. The Chronic Pain Medical Treatment Guidelines allow for initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 24 chiropractic visits is more than what is medically necessary to establish whether the treatment is effective. Original reviewer modified request from 24 visits to 6 visits. 24 chiropractic visits for the left knee and lumbar spine is not medically necessary.

**MRI of the lumbar spine and left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341, 343. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, MRIs (magnetic resonance imaging).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** The MTUS states that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. The medical record fails to document sufficient findings indicative of nerve root compromise, which would warrant an MRI of the lumbar spine. Original reviewer modified the request to include the left knee only. MRI of the lumbar spine and left knee is not medically necessary.

**X-ray of the lumbar spine and left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Knee Chapter, Radiography (x-rays).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic), Radiography (x-rays).

**Decision rationale:** Physical exam failed to reveal any evidence of joint effusion, swelling, ecchymosis, deformity, increased warmth, or abrasion/laceration. The findings documented on the chart note failed to meet the minimum criteria stated in the Official Disability Guidelines for x-ray imaging of the knee. X-ray of the lumbar spine and left knee is not medically necessary.