MAXIMUS Federal Services

Case Number:	CM15-0134009		
Date Assigned:	07/22/2015	Date of Injury:	01/08/2008
Decision Date:	08/24/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	07/10/2015

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: New Jersey, New York
Certification(s)/Specialty: Family Practice

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 57 year old male sustained an industrial injury on 1/08/08. He subsequently reported knee, leg, shoulder and low back pain. Diagnoses include right knee strain, lumbar disc herniation and right shoulder rotator cuff syndrome. Treatments to date include MRI testing, injections, lumbar spine, knee and shoulder surgeries, physical therapy and prescription pain medications. The injured worker continues to experience low back pain that radiates into the bilateral lower extremities as well as right shoulder and bilateral knee pain. Upon examination of the lumbar spine, palpation of the paraspinal muscles revealed tenderness and hypertonicity bilaterally. Straight leg raise was positive on the left, Kemp's was positive bilaterally. Right shoulder examination reveals reduced ranges of motion and positive Neer's and Hawkin's impingement testing. Bilateral knee flexion was reduced and patellofemoral grind test was positive bilaterally. A request for Compound Rx: Keratek Gel (Methylsalicyta/methol) 4oz was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound Rx: Keratek Gel (Methylsalicyta/methol) 4oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic, Salicylate topicals Page(s): 111-113, 104.

Decision rationale: Keratek (Menthyl salicylate, menthol) topical gel is not medically necessary. The use of topical analgesics is largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when anti-depressants and anti-convulsants have failed. According to MTUS guidelines, any compounded product that contains at least one drug that is not recommended is not recommended. Methyl salicylate may be useful for chronic pain and may improve his pain. However, there are no guidelines for the use of menthol with the patient's complaints. It is unclear if patient is unable to tolerate all oral analgesics. Therefore, the request is considered not medically necessary.