

<b>Case Number:</b>	CM15-0146449		
<b>Date Assigned:</b>	08/07/2015	<b>Date of Injury:</b>	07/05/2011
<b>Decision Date:</b>	09/04/2015	<b>UR Denial Date:</b>	07/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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: 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 46 year old male, who sustained an industrial injury on 7-5-2011. Diagnoses have included right full thickness rotator cuff tear and impingement with acromioclavicular joint arthrosis. Treatment to date has included magnetic resonance imaging (MRI), right shoulder and right wrist surgery, physical therapy, injections and medication. According to the orthopedic consult dated 6-4-2015, the injured worker complained of right shoulder pain. He complained of neck pain radiating down the right arm to the fingers with associated numbness and tingling. Exam of the cervical spine revealed decreased range of motion and paracervical muscle spasm and tenderness. Exam of the right shoulder revealed tenderness and positive impingement sign. Authorization was requested for Menthoderm gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Menthoderm Gel 120g:** Upheld

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

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

**Decision rationale:** Regarding the request for Methoderm, this topical compound is a combination of methyl salicylate and menthol (according to the Methoderm website). Guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the Methoderm is for short-term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Methoderm is not medically necessary.