

<b>Case Number:</b>	CM15-0224701		
<b>Date Assigned:</b>	11/23/2015	<b>Date of Injury:</b>	09/02/2014
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/16/2015

### 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: Maryland

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

The injured worker is a 39 year old female, who sustained an industrial injury on September 2, 2014, incurring left shoulder, upper and lower back injuries. She had a history of lumbar surgery in 2005. She was diagnosed with a left shoulder impingement syndrome, adhesive capsulitis, cervical sprain and lumbar sprain. Treatment included physical therapy, anti-inflammatory drugs, and pain medications, cortisone injections, and topical analgesic cream and restricted activities. She underwent a left shoulder decompression with rotator cuff repair on July 28, 2015. Currently, the injured worker complained of constant cervical and lumbar spine pain with reduced range of motion. She also noted persistent left shoulder pain. The injured worker complained of cervical and lumbar muscle spasms and decreased range of motion with tenderness. The chronic pain and limited range of motion interfered with her daily activities. The treatment plan that was requested for authorization included a prescription for Methoderm 240 gm and an evaluation for range of motion. On October 21, 2015, a request for a prescription for Methoderm and an evaluation for range of motion was non-certified by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methoderm 240gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Salicylate topicals, Topical Analgesics.

**Decision rationale:** Mentherm 240gm is not medically necessary per the MTUS guidelines. Mentherm is a topical analgesic used for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness. The active ingredients are Methyl Salicylate 15.00% and Menthol 10.00% . The MTUS states that salicylate topical is significantly better than placebo in chronic pain. Menthol is an ingredient in Ben Gay which is a topical salicylate. The MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no evidence of intolerance to oral medications or failure of anticonvulsants and antidepressants necessitating the need for this topical analgesic. The request for Mentherm is not medically necessary.

**Range of motion:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, updated 09/22/15, Flexibility.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Physical Examination, and Low Back Complaints 2004, Section(s): Physical Examination. Decision based on Non-MTUS Citation (ODG) Neck- Flexibility.

**Decision rationale:** The request for range of motion is not medically necessary per the MTUS and the ODG guidelines. The ODG states that flexibility is not recommended as a primary criteria. The relation between back range of motion measures and functional ability is weak or nonexistent. The MTUS ACOEM guidelines state that because of the marked variation among persons with and without symptoms, range-of-motion measurements of the neck and upper back are of limited value except as a means to monitor recovery in cases of restriction of motion due to symptoms. The MTUS states that when examining the shoulder the examiner may determine passive ROM by eliminating gravity in the pendulum position or by using the other arm to aid elevation. The request as written does not specify what body part the range of motion is requested for. The guidelines state that there is limited value of range of motion testing for the neck and low back and the shoulder exam as part of a routine office visit should include range of motion testing. There is no reason that there needs to be specialized range of motion testing for the spine or shoulder other than what would be part of a routine history and physical therefore this request is not medically necessary.