MAXIMUS Federal Services

Case Number:	CM15-0054097		
Date Assigned:	03/27/2015	Date of Injury:	01/05/2010
Decision Date:	05/01/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	03/23/2015

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: Arizona, California
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 52 year old female sustained an industrial injury to the back and left shoulder on 1/5/10. Previous treatment included magnetic resonance imaging, shoulder surgery, sacroiliac injections, trigger point injections, acupuncture, transcutaneous electrical nerve stimulator unit, physical therapy and medications. In a Need for Additional Treatment Supplemental Report dated 2/20/15, the physician indicated that the injured worker was being treated for chronic bilateral upper and lower extremity neuropathic pain secondary to cervical radiculopathy, lumbar spine radiculopathy and myofascial pain syndrome. The physician was appealing a denial for transcutaneous electrical nerve stimulator unit replacement pads and trigger point injection. The physician noted that trigger point injections and transcutaneous electrical nerve stimulator unit had provided pain relief and increased functional mobility. No physical exam was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Menthoderm gel #2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 105, 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesic Page(s): 111-112.

Decision rationale: Menthoderm contains topical methyl salicylate (NSAID). According to the MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. In this case, there are no exam findings to corroborate necessity of Menthoderm. In addition, no indication of pain relief or reduction in any oral medications were noted to justify a quantity of 2 Menthoderms. The use of Menthoderm is not substantiated and not medically necessary.