

<b>Case Number:</b>	CM14-0115279		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	09/27/2011
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	07/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2014

### 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. The expert reviewer is Board Certified in Family Practice and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 52-year-old female who reported an injury of unknown mechanism on 09/27/2011. On 11/20/2013, her diagnoses included cervical strain/sprain, thoracic sprain/strain, lumbar sprain/strain and shoulder sprains. Her complaints included chronic pain in the neck, upper and lower back with pain radiating down the right arm and left leg with associated numbness rated at 7/10 to 8/10. Her medications included Norco 2.5 mg, tramadol ER 150 mg, gabapentin 600 mg, Flexeril 7.5 mg, Naprosyn 550 mg, Protonix 20 mg, Flurbiprofen cream and Menthoderm gel. Rationale for the Menthoderm gel was to decrease her pain locally. There was no Request for Authorization included in this injured worker's chart.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Request: Menthoderm Gel (Duration and Frequency Unknown) Dispensed on 11/20/2013:** 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:** The request for retrospective request Menthoderme gel, duration and frequency unknown, dispensed on 11/20/2013, is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. Many agents are compounded for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Menthoderme gel contains methyl salicylate and menthol. Methyl salicylate has not been evaluated by the FDA for topical use in humans. The use of this compounded product is not supported by the guidelines. Additionally, the body part or parts that were to have been treated were not included in the request. Furthermore, there was no frequency of application or quantity included with the request. Therefore, this request for Menthoderme gel, duration and frequency unknown, dispensed on 11/20/2013, is not medically necessary.