

Case Number:	CM14-0183408		
Date Assigned:	11/10/2014	Date of Injury:	07/02/2011
Decision Date:	12/16/2014	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/04/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California and Washington. 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 47-year-old male who reported an injury on 07/02/2011. The mechanism of injury was the injured worker was employed as a stocker for a tire company and sustained injury while stacking tires onto a trailer. Prior therapies were noted to include chiropractic care, a TENS unit, and acupuncture as well as medications. The injured worker's medications include gabapentin, tramadol ER, naproxen, omeprazole, cyclobenzaprine, and methyl salicylate analgesic gel. His surgical history was stated to be none. The documentation of 09/05/2014 revealed the injured worker had pain in the neck, upper back, both shoulders, and both elbows, with radiation to the bilateral arms and wrists. The injured worker complained of pain in the midback, low back, and bilaterally to the knees with radiation. The injured worker's symptoms included an associated numbness in the arms and weakness in the legs. The pain was relieved with doing exercises and the use of the TENS unit. The physical examination revealed the injured worker's range of motion was decreased. The rotation was limited. The injured worker had a positive lumbar facet loading maneuver bilaterally. There was a positive straight leg raise on the left in the seated position to 50 degrees. The sensation examination revealed diminished sensation in the left at L5 and S1 dermatomes of the lower extremities. There was normal motor muscle testing. The reflexes were symmetric at 1+/4 in the bilateral lower extremities. The diagnoses for this date of service included lumbago and lumbar radiculopathy. The request was made for methyl salicylate 15% analgesic gel to be used 2 to 3 times per day as needed 120 mL. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription for Menthoderm for date of service 9/5/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines.

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate 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. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines further indicate that topical salicylates are appropriate for the treatment of pain. The clinical documentation submitted for review failed to indicate the injured worker had a trial and failure of antidepressants and anticonvulsants. The duration of use could not be established. The request as submitted failed to indicate the frequency as well as the quantity of medication being requested. Given the above, the request for 1 prescription for Menthoderm for date of service 9/5/2014 is not medically necessary.