

<b>Case Number:</b>	CM15-0019319		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	04/13/2011
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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

### 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 59 year old female, who sustained an industrial injury on 04/13/2011. The diagnoses have included cervical disc disease, thoracic spine sprain/strain, lumbar disc disease, and lumbar radiculopathy. Noted treatments to date have included chiropractic treatment, aqua therapy, home exercise program, epidural steroid injections, and medications. Diagnostics to date have included normal electromyography/nerve conduction studies per progress note and no MRI report noted in received medical records. In a progress note dated 12/09/2014, the injured worker presented with complaints of cervical, lumbar, and thoracic spine pain. The treating physician reported tenderness to palpation to cervical, lumbar, and thoracic spine. Utilization Review determination on 01/02/2015 non-certified the request for Methoderm Cream citing Medical Treatment Utilization Schedule Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methoderm Cream:** Upheld

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

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

**Decision rationale:** Per the 12/09/14 report the patient presents with pain in the lumbar, thoracic and cervical spine. The current request is for MENTHODERM CREAM per the 12/09/14 RFA. Recent reports do not state if the patient is working. The MTUS page 111 states that Topical Analgesics (NSAIDs) are indicated for peripheral joint arthritis/tendinitis. Methoderm is a compound analgesic containing Methyl Salicylate and Menthol. In this case, the reports provided for review do not show clinical findings or diagnoses of peripheral joint arthritis for which this medication is indicated. Therefore, the request IS NOT medically necessary.