

<b>Case Number:</b>	CM14-0102821		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	01/31/2013
<b>Decision Date:</b>	09/30/2014	<b>UR Denial Date:</b>	06/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2014

### 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 Internal Medicine, has a subspecialty in Pulmonary Disease and is licensed to practice in California, Florida and New York. 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 female of unknown date of birth who reported an injury on 01/31/2013. The mechanism of injury was noted to be a fall. The injured worker's diagnoses were noted to be lumbago, left leg joint pain, long-term use of medications and generalized pain. Her prior treatments were noted to be topical medications and therapy. She was noted to have diagnostic imaging studies. On 07/07/2014, the injured worker was noted to have subjective complaints of low back, right foot pain described as an 8/10 on a 0 to 10 scale. Objective findings were noted to be the injured worker was fully ambulatory without aids, motor strength was 5/5, in the back and lower extremities. Reflexes were 2+ and symmetric throughout. She had no sensory deficits. Straight leg raising was negative to 55 degrees bilaterally. There was no atrophy of the thigh or calf. She demonstrated full range of motion of the right foot. She did not have a brace on the right foot for support. The treatment plan was for a compound cream for pain management. The rationale for the request was provided within the treatment plan. A request for authorization form was not provided within the documentation submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for Methoderm 120ml DOS:5/12/14:** 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): 111-112.

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111-112. The Expert Reviewer's decision rationale: The request for retrospective Menthoderm 120 ml DOS: 05/12/2014 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines state "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. These agents are applied locally to painful areas with advances that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many of these agents are compounded as monotherapy or in combination 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 one drug or drug class that is not recommended is not recommended. The medication submitted for review is a topical salicylate and is appropriate for the treatment of pain. The clinical documentation submitted for review, does not indicate a failed trial of antidepressants or anticonvulsants. In addition, the provider's request fails to indicate a frequency.