

Case Number:	CM13-0044709		
Date Assigned:	12/27/2013	Date of Injury:	02/07/2012
Decision Date:	02/24/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/31/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. She has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pediatric Rehabilitation Medicine and is licensed to practice in Illinois, and Texas. 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 physician reviewer was selected based on 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. 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 patient is a 54-year-old female who reported a work related injury on 02/07/2012, specific mechanism of injury not stated. The patient presents for treatment of the following diagnoses: lumbar radiculopathy, right shoulder internal derangement, and anxiety reaction. The clinical note dated 09/17/2013 reports the patient was seen under the care of [REDACTED]. The provider documents the patient reports continued complaints of pain about the right shoulder rated at a 7/10. Upon physical exam, of the patient, anterior right shoulder tenderness upon palpation was noted. Range of motion was restricted and the patient presented with a positive impingement sign. The lumbar spine exam revealed paraspinal muscles were tender and spasms were noted. Range of motion was restricted. Straight leg testing was positive bilaterally. The provider administered the following refills of medications: ketoprofen 75 mg 1 by mouth q. day, Omeprazole DR 20 mg 1 by mouth q. day, orphenadrine ER 100 mg 1 tab by mouth 2 times a day, hydrocodone 5/325 one tab by mouth 2 times a day, and Medrox pain relief ointment 2 times a day.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medrox pain relief ointment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: The Physician Reviewer's decision rationale: The current request is not supported. The clinical documentation submitted for review fails to evidence the patient's duration and frequency of treatment or efficacy of treatment as a result of utilizing Medrox ointment for her chronic pain complaints. The clinical notes failed to document an increase in objective functionality and a decrease in rate of pain on a VAS scale as a result of utilization of Medrox ointment. California MTUS indicates 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. The clinical notes do not indicate the patient presents with complaints of neuropathic pain or that the patient has failed with a trial of anticonvulsants or other oral analgesics for neuropathic complaints. Given all of the above, the request for Medrox pain relief ointment is not medically necessary or appropriate.