

Case Number:	CM13-0044745		
Date Assigned:	12/27/2013	Date of Injury:	11/25/2008
Decision Date:	02/25/2014	UR Denial Date:	10/03/2013
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. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in California. 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 physician 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 46-year-old female with a date of injury of 11/25/2008. The patient has a history of prior C5-7 anterior discectomy and fusion and removal of hardware. She has diagnoses of bilateral shoulder impingement syndrome with superior labral tears, right elbow lateral and medial epicondylitis, and lumbar discopathy and facet arthropathy. According to a progress report on date of service 8/20/13, the patient complained of persistent neck pain with stiffness, low back pain radiating to lower extremities with numbness and tingling, as well as unchanged bilateral shoulder and right elbow pain. Cervical and lumbar paravertebral muscle tenderness and terminal motion pain were reported. The objective findings also included right lateral and medial epicondyle tenderness and terminal flexion pain, positive Cozen's sign, positive seated nerve root test. The treatment plan included a request for Medrox ointment for "topical relief of minor aches, muscular and neuropathic pain." The disputed issue is a request for Medrox ointment x 2. The utilization review determination stated that the methyl salicylate and capsaicin are not indicated in this case, and therefore the Medrox ointment was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Two prescriptions of Madrox pain ointment, 120 grams: Upheld

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

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

Decision rationale: Medrox is a compounded topical medication consisting of methyl salicylate, menthol, and capsaicin 0.0375%. The Chronic Pain Medical Treatment Medical Guidelines on page 111 states "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Thus, each active ingredient should be analyzed in making a determination of medical necessity. For methyl salicylate, the Chronic Pain Medical Treatment Medical Guidelines on page 105, with regard to salicylate topical, says, "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004) See also Topical analgesics; & Topical analgesics, compounded." For capsaicin, there are 2 distinct areas of the Chronic Pain Medical Treatment Medical Guidelines where capsaicin is referenced. On pages 28-29 the following statement regarding topical capsaicin says, "Recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. The number needed to treat in musculoskeletal conditions was 8.1. The number needed to treat for neuropathic conditions was 5.7. (Robbins, 2000) (Keitel, 2001) (Mason-BMJ, 2004) The results from this RCT support the beneficial effects of 0.025% capsaicin cream as a first-line therapy for OA pain. (Altman, 1994) Mechanism of action: Capsaicin, which is derived from chili peppers, causes vasodilation, itching, and burning when applied to the skin. These actions are attributed to binding with nociceptors, which causes a period of enhanced sensitivity followed by a refractory period of reduced sensitivity. Topical capsaicin is superior to placebo in relieving chronic neuropathic and musculoskeletal pain. Capsaicin produces highly selective regional anesthesia by causing degeneration of capsaicin-sensitive nociceptive nerve endings, which can produce significant and long lasting increases in nociceptive thresholds. (Maroon, 2006) Adverse reactions: Local adverse reactions were common (one out of three patients) but seldom serious (burning, stinging, erythema). Coughing has al