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| Case Number: | CM13-0068427 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 08/19/2009 |
| Decision Date: | 04/22/2014 | UR Denial Date: | 11/25/2013 |
| Priority: | Standard | Application Received: | 12/19/2013 |

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 Family Practice and is licensed to practice in Texas. 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 patient is a 54-year-old female who reported an injury on 08/19/2009. The mechanism of injury was not provided in the medical records. The patient was diagnosed with pain in the joint, shoulder region. The patient's symptoms include a pain level of a 5/10. Her pain is noted to be constant with a dull and colicky sensation. The pain radiated to her head, back, elbow and fingers. The patient was complaining of numbness and a pins/needles sensation as well as weakness due to the pain. Examination of the left shoulder revealed restricted range of motion with flexion of 90 degrees, limited by pain; and abduction limited to 90 degrees, limited by pain. Past medical treatment has included acupuncture, physical therapy and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

PROTONIX 20MG #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: According to the California MTUS Guidelines, proton pump inhibitors are recommended for the treatment of dyspepsia secondary to nonsteroidal anti-inflammatory drug

(NSAID) therapy. The documentation submitted for review indicated that the patient is currently taking an NSAID; however, the documentation failed to provide evidence of any gastrointestinal disorders or that the patient complained of dyspepsia. Therefore, the requested Protonix is not medically necessary at this time.

MENTHODERM GEL 120ML #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105 AND 111.

Decision rationale: According to the California MTUS Guidelines, topical analgesics are largely experimental in use, with few randomized controlled trials to determine efficacy or safety; also, they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control; however, there is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. While the guidelines support the use of salicylate topical drugs, they fail to reveal any guidelines or scientific evidence to support the use of menthol. The documentation submitted for review failed to provide evidence of the need for a combination topical analgesic. As the requested medication is a compounded product that contains at least 1 drug that is not recommended, the request is not supported. Therefore, the requested Methoderm gel is not medically necessary or appropriate.