

Case Number:	CM14-0025325		
Date Assigned:	06/11/2014	Date of Injury:	10/02/2013
Decision Date:	07/16/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	02/27/2014

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 Physical Medicine & Rehabilitation 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 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 39-year-old female who reported an injury on 10/02/2013; the mechanism of injury was not provided within the medical records. The clinical note dated 06/04/2014 indicated diagnoses of a knee sprain/strain and a history of gastritis. The injured worker reported a recent fall at home. She reported that due to right knee instability which caused injury to right ankle and right toe. The injured worker reported that she underwent self-treatment with ice and Epsom salt and she reported left ankle swelling. On physical exam, the injured worker had an antalgic gait. The injured worker had limited range of motion to the right knee. The injured worker had tenderness to palpation of the medial patella and right ankle and foot. The injured worker had tenderness to palpation of the left knee medial aspect. The injured worker had decreased sensation in the lower extremities, right greater than left. The injured worker had weakness in the right lower extremity. The injured worker ambulated with a cane on the right side. The injured worker's prior treatments have included a home exercise program and a medication regimen. The provider submitted a request for omeprazole and Methoderm gel. The treatment plan was to continue with the home exercise program and medications with a request for physical therapy and a psychiatric evaluation. A Request for Authorization was not submitted for review, to include the date that the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

OMEPRAZOLE 20MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS,GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Work Loss Data Institute LLC; Corpus Christi TX; www.odg-twc.com; Section: Knee & Leg (Acute & Chronic).

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

Decision rationale: The request for Omeprazole 20MG #30 is not medically necessary. The California Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors when the patient is at intermediate risk for gastrointestinal events and on NSAIDs. Although the injured worker has a history of gastritis, there is a lack of documentation of efficacy and functional improvement with the medication. In addition, the provider did not indicate a frequency for the medication. Therefore, the request for omeprazole 20 mg for 30 tablets is not medically necessary.

MENTHODERM GEL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Work Loss Data Institute LLC; Corpus Christi TX; www.odg-twc.com; Section: Knee & Leg (Acute & Chronic).

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

Decision rationale: The request for Methoderm Gel is not medically necessary. The California Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. 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 guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There was lack of documentation of neuropathic pain. In addition, there was lack of documentation submitted to indicate that the trials of antidepressants or anticonvulsants had failed. Furthermore, the provider did not indicate a dosage, frequency or quantity for the Methoderm gel. Therefore, the request for Methoderm gel is not medically necessary.