

Case Number:	CM14-0033791		
Date Assigned:	06/20/2014	Date of Injury:	05/10/2011
Decision Date:	07/24/2014	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	03/17/2014

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 Illinois. 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 with a reported injury on 05/10/2011. The mechanism of injury was not provided within the clinical notes. The clinical note dated 03/17/2014 reported that the injured worker complained of lower back pain. The pain was characterized as aching and pressure. The physical examination of the injured worker's lumbar spine revealed range of motion being restricted demonstrating flexion to 60 degrees and extension limited to 10 degrees. Paravertebral muscles were normal as per examination report. Straight leg raise test was positive to the left side at 90 degrees. The sensory examination demonstrated light touch sensation was decreased over the L5-S1 dermatomes on the left side. The injured worker's diagnoses included thoracic/lumbosacral neuritis/radiculitis not otherwise specified; chronic pain syndrome; and skin sensation disturbance. The injured worker's prescribed medication list included hydrocodone 10/325 mg and Terocin (with lidocaine). The provider requested Menthoderm gel and Protonix, the rationales were not provided within the clinical notes. The request for authorization was submitted on 03/03/2014. The injured worker's prior treatments included pain psychiatric therapy, exercise, medication therapy, and acupuncture.

IMR ISSUES, DECISIONS AND RATIONALES

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

Menthoderm Gel, 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation <http://www.drugs.com/cdi/menthoderm-cream.html>.

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

Decision rationale: The request for Methoderm gel, 120 gm is not medically necessary. The injured worker complained of lower back pain. The treating physician's rationale for Methoderm gel was not provided within the clinical notes. The CA MTUS guidelines recommend Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. Methoderm gel's active Ingredients consist of methyl salicylate 15% & menthol 10%. There is a lack of clinical information provided documenting the efficacy of Methoderm gel as evidenced by decreased pain and significant objective functional improvements. Moreover, it cannot be determined if Methoderm gel is an ongoing prescription or the initiation of therapy. Furthermore, the requesting provider did not specify the utilization frequency or the location of application of the medication being requested. As such, the request is not medically necessary.

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 (ODG): proton pump inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request for Protonix 20 mg, #60 is not medically necessary. The injured worker complained of lower back pain. The treating physician's rationale for Protonix was not provided within the clinical notes. The CA MTUS guidelines recommend the use of proton pump inhibitors if there is a history of gastrointestinal bleeding or perforations, a prescribed high dose of NSAIDs and a history of peptic ulcers. There is also a risk with long-term utilization of PPI (> 1 year) which has been shown to increase the risk of hip fracture. There is a lack of clinical information provided indicating the injured worker has gastritis. There is a lack of documentation of NSAID side effects reported by the injured worker that would warrant the use of a proton pump inhibitor. Moreover, there is a lack of clinical information provided indicating how long the injured worker has used Protonix. The guidelines identify increased risk of hip fracture with long-term usage of PPIs. The injured worker also fails to fit the criteria of any significant risk for gastrointestinal bleeding or perforations. Furthermore, the requesting provider did not specify the utilization frequency of the medication being requested. As such, the request is not medically necessary.