

<b>Case Number:</b>	CM14-0074835		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	11/01/2010
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	05/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2014

### 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 Texas & Oklahoma. 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 36-year-old male who reported injury on 11/01/2010, reportedly he fell off a chair about 3 feet onto his right shoulder, which was at his side. He developed pain in the right shoulder, which has persisted. The injured worker's treatment history included physical therapy, medications, MRI studies, injections, and urine drug screen. The injured worker was evaluated on 04/23/2014 and it was documented that the injured worker complained of frequent 9/10 burning, right shoulder pain reaching overhead and reaching back, pops and catches, swelling, low back constant pain 8/10 worsened with bending, twisting, lifting. Pain radiated to bilateral legs to toes, headaches for approximately 2 months. Objective findings; right shoulder, tender anterior, acromial margin. Tender AC joint. Range of motion: Flexion was 160 degrees, external rotation was 70 degrees and internal rotation was 60 degrees. Positive Speed's test. Positive impingement test. Tender lumbar paraspinal, pain with range of motion. Lumbar range of motion is decreased and painful. Flexion was 40 degrees. Left/right lateral bending was 22 degrees, and right lateral bending was 15 degrees. The provider failed to indicate the injured worker having gastrointestinal events. The medications included tramadol, naproxen, Prilosec, Methoderm ointment. Diagnoses included right shoulder pain and dysfunction, right shoulder AC joint arthrosis, right shoulder impingement with bursitis, and lumbar strain. The Request for Authorization or rationale was not submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methoderm ointments:** Upheld

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

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

**Decision rationale:** The requested is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product contains at least one drug (or drug class) that is not recommended. Mentherm ointment contains at least one or more drug class. The guidelines state that there are no other commercially approved topical formulation of Lidocaine (whether creams, lotions, or gels) that are indicated for neuropathic pain other than Lidoderm. The proposed gel contains methyl salicylate and menthol. Furthermore, there was no documentation provided on conservative care measures such as physical therapy or pain management. In addition, there was no documentation provided on frequency or location where the Mentherm ointment would be applied and unspecified quantity of the ointment was not provided. As such, the request for retrospective request for Mentherm ointment is not medically necessary.

**Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitor.

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

**Decision rationale:** The requested is not medically necessary. Per California Medical Treatment Utilization Schedule (MTUS) Guidelines, Protonix is recommended for patients taking NSAIDs who are at risk of gastrointestinal events. The documentation provided did not indicate that the injured worker was having gastrointestinal events. In addition, the request lacks the frequency or duration of the medication for the injured worker. Given the above, the request for Prilosec 20 mg is not medically necessary.