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| Case Number: | CM15-0213340 | | |
| Date Assigned: | 11/03/2015 | Date of Injury: | 09/17/2014 |
| Decision Date: | 12/23/2015 | UR Denial Date: | 10/07/2015 |
| Priority: | Standard | Application Received: | 10/30/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 72-year-old male with a date of industrial injury 9-17-2014. The medical records indicated the injured worker (IW) was treated for cervical strain; right shoulder strain; and right shoulder bursitis with adhesive capsulitis. In the progress notes (7-21-15), the IW reported neck pain. On examination (7-21-15 notes), right shoulder forward flexion was 110 degrees and abduction was 105 degrees, compared to left shoulder forward flexion 140 degrees and abduction 120 degrees. Cervical spine was 40-35 (not clearly described) and 80 degrees rotation right and left. Treatments included cervical epidural steroid injection (without relief) and physical therapy. The IW was working, with restrictions. A Request for Authorization was received for Ortho- nestic gel 6-ounce tube. The Utilization Review on 10-7-15 non-certified the request for Ortho- nestic gel 6-ounce tube.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ortho-nesic gel 6-oz tube: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) 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 requested medication contains ingredients Menthol and camphor, which are not indicated per the California MTUS for topical analgesic use for shoulder strain or cervical neck pain or bursitis. Therefore, the request is not medically necessary.