

Case Number:	CM14-0147945		
Date Assigned:	09/15/2014	Date of Injury:	05/21/2013
Decision Date:	10/15/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	09/11/2014

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 and 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 49-year-old male who reported an injury on 05/21/2013. The mechanism of injury was not submitted for review. The injured worker has diagnoses of degenerative disc disease, lumbar facet arthropathy, lumbar radiculopathy, lumbar HNP with bilateral neural foraminal narrowing, and thoracic HNP. Past medical treatment consists of TESI, chiropractic therapy, E-stim, physical therapy, hot and cold packs, and medication therapy. Medications consists of hydrocodone and Menthoderm cream. On 09/03/2014, the injured worker complained of low back pain. Physical examination had noted that the injured worker's pain was 9/10. Range of motion of the lumbar spine revealed flexion of 25 degrees, extension of 10 degrees, right lateral bend at 15 degrees, and left lateral bend at 15 degrees. Sensory examination of the lower extremity revealed sensation to be intact on the right, sensation decreased on the L4-5 and S1 dermatomes. Lower extremity motor strength was 5/5. The treatment plan is for the injured worker to continue the use of medication. The provider feels that the medications are needed to help manage pain levels of the injured worker. The Request for Authorization form was not submitted for review

IMR ISSUES, DECISIONS AND RATIONALES

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

Menthoderm gel 4oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation <http://www.physiciansproducts.net/product/menthoderms/>

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

Decision rationale: The request for Menthoderms is not medically necessary. The MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. Also, they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. 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 drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of specific analgesic effect of each agent and how it will be useful for specific therapeutic goal required. Menthoderms consists of methyl salicylate 15% and menthol 10%. Given the above, Menthoderms is not recommended by the MTUS. Furthermore, there was no literature to support efficacy and advantage over OTC medication or other medications already being prescribed. Additionally, there was no evidence of antidepressants and anticonvulsants having been tried and failed. The request as submitted also did not specify a dosage, frequency, or duration of the medication. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Hydrocodone 5/325mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Hydrocodone, Ongoing Management, Page(s): page 75, page 78.

Decision rationale: The request for hydrocodone 5/325 is not medically necessary. The California MTUS Guidelines recommend short acting opioids, such as hydrocodone, for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. An assessment including what pain levels are before, during, and after medication administration should also be documented. The submitted documentation did not indicate that the hydrocodone was helping the injured worker with any functional deficits. Additionally, the efficacy of the medication was not submitted for review. Furthermore, there were no drug screens or urinalysis submitted for review showing that the injured worker was in compliance with medication. The documentation also lacked evidence on what pain levels were before, during, and after the medication. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request for hydrocodone is not medically necessary.

