

Case Number:	CM14-0163901		
Date Assigned:	10/08/2014	Date of Injury:	05/16/2009
Decision Date:	12/24/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	10/06/2014

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 Emergency Medicine 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 patient reported date of injury on 5/16/14. No mechanism of injury was provided. Diagnosis include R shoulder rotator cuff syndrome, R shoulder acromioclavicular joint arthrosis post distal clavicle excision, L shoulder rotator cuff syndrome, L shoulder acromioclavicular joint arthrosis post distal clavicle excision, R knee chronic strain, chronic lumbar strain, high blood pressure, acid reflux and erectile dysfunction. Medical reports reviewed. Last report available until 7/28/14. Patient complains of low back, bilateral shoulder and R knee pain. Pain is constant to back and intermittent to shoulders and knee. Pain is 6-7/10. Pain is "better" with medications improving pain from 7 to 2-3/10. Objective exam reveals normal ambulation and in no distress. Lumbar spine had decreased range of motion (ROM) with tenderness to paraspinal muscles. Positive Kemp's sign bilaterally, positive straight leg raise on R side. Strength was normal. Shoulder exam reveals decreased ROM, tenderness over AC joints with decreased strength with flexion and abduction on R side. Note records no signs of abuse or side effects however, no pain contract, CURES search or urine drug screen was submitted. Topical products was request due to stomach issues with NSAIDs. Independent Medical Review is for Diclofenac/Lidocaine 3/5% #180g and Kera-Tek gel #4oz and Anexsia 7.5/325mg #120. Prior UR on 9/8/14 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac/lidocaine (3%/5%) 180g #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

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

Decision rationale: As per MTUS guidelines "Any compound product that contains a drug or drug class that is no recommended."1) Diflofenac: Recommended for short term use. May be beneficial.2) Lidocaine: Topical lidocaine is recommended for post-herpetic neuralgia only although it may be considered as off-label use as a second line agent for peripheral neuropathic pain. It may be considered for peripheral neuropathic pain only after a trial of 1st line agent. Patient does not have any documentation consistent with neuropathic pain except for low back pains with some radicular signs. Patient does not meet indication for Lidocaine use. Diclofenac/Lidocaine is not medically necessary.

Kera-Tek analgesic gel 4oz #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

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

Decision rationale: The requested product is a patch composed of multiple medications. As per MTUS guidelines, "Any compounded product that contain one drug or drug class that is not recommended." Kera-Tek is a brand specific medication containing methyl-salicylate and menthol. 1) Methyl-Salicylate: As per MTUS Chronic pain guidelines, methyl-Salicylate is recommended for osteoarthritis to areas that may be amenable to topical therapy. There is no evidence for its efficacy in the spine, hip or shoulder. Patient has shoulder, knee and low back pains. It is not clear from the documentation, where this medication is being specifically directed at. 2) Menthol: There is no information in the MTUS Chronic pain, ACOEM guidelines of Official Disability Guidelines concerning menthol. There appears to be some topical soothing effect but no evidence is available to support this affect. The request is specific to a brand name product. There is no documentation as to why Kera-Tek was specially requested. While Methyl-Salicylate may be recommended for a short term trial for patient's pain in knee, it is not clear from the documentation as to where it is being applied since shoulder related pains seem to be the most at issue. Menthol is not a specific medication with any recommendation available. Due to lack of documentation of where this medication is to be applied, whether to a recommended area or a non-recommended area and the lack of documentation as to why a brand specific medication was ordered; Kera-Tek is not medically necessary.

Anexsia 7.5/325mg #120 DOS 7/28/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78.

Decision rationale: Anexsia is acetaminophen and hydrocodone, an opioid. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. The documentation fails to document functional objective improvement in pain or function. There is some documentation of pain improving to 2-3/10 but no documentation of improvement in function or decrease in medication use. There is no appropriate documentation of screening for abuse with no appropriate documentation of screening interview, CURES review or urine drug screening. Guidelines also recommend long term plan for opioid management. Anexsia is not medically necessary.