

Case Number:	CM13-0013766		
Date Assigned:	09/27/2013	Date of Injury:	04/12/2012
Decision Date:	01/14/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/19/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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.

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 underlying date of injury in this case is 04/12/2012. Treating diagnoses include lumbosacral myofasciitis, calcified tendinitis of the shoulder, and shoulder strain. There may be other diagnoses which are not legible in the handwritten physician notes. A physician review in this case reports that multiple prior requests for medications have been noncertified and that additional approval of medication had been requested and was not available. I cannot identify in the records additional information beyond that documented by the initial physician reviewer, or alternatively this information may be present but essentially not legible.

IMR ISSUES, DECISIONS AND RATIONALES

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

(1) prescription for Genicin 500 mg # 90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine and Chondroitin Sulfate Page(s): 50.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Glucosamine and Chondroitin Sulfate, page 50, states, "Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis." The medical records do not provide a rationale for this medication consistent with the guideline diagnoses. The request for one (1) prescription for Genicin 500 mg # 90 is not medically necessary and appropriate.

(1) prescription for Flurb/cream # 180: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Topical Analgesics, page 111, states, "The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required." The medical records in this case do not provide specific information to meet this guideline regarding an indication for this requested treatment. This treatment is not medically necessary. The request for one (1) prescription for Flurb/cream # 180 is not medically necessary and appropriate.

(1) prescription for Gabacyclotram 180 gm: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Topical Analgesics, page 111, states, "The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal require. Any compounded product that contains at least one drug class that is not recommended is not recommended, Gabapentin is not recommended there is no peer-reviewed literature to support its use. Additionally, there is no evidence for use of any other muscle relaxant as a topical product." Therefore at least 2 component medications in this request are specifically not recommended by the treatment guidelines. Overall this request is not medically necessary. The request for one (1) prescription for Gabacyclotram 180 gm is not medically necessary and appropriate.

(1) prescription for Laxacin # 100: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Opioids, Initiating Therapy, page 77, states, "Prophylactic treatment of constipation should be initiated."

The medical records do not clearly document an indication for constipation or for opioid use. The records are very limited in this regard and therefore again do not meet the criteria per the guidelines. This request is not medically necessary

(1) prescription for Somnicin # 30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section on Treatment of Worker's Compensation/Pain/Insomnia.

Decision rationale: This request is not specifically discussed in the Chronic Pain Medical Treatment Guidelines. The Official Disability Guidelines, Treatment of Workers' Compensation/Pain/Insomnia states, "Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance." The medical records do not document such a detailed evaluation regarding the cause of the patient's sleep difficulties. The records do not provide sufficient information to support a rationale for this request. The request for one (1) prescription for Somnicin # 30 is not medically necessary and appropriate.