

<b>Case Number:</b>	CM13-0034550		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	07/02/2012
<b>Decision Date:</b>	05/22/2014	<b>UR Denial Date:</b>	09/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2013

### 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, has a subspecialty in Sports Medicine, and is licensed to practice in Texas. 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 52-year-old male who reported an injury on 07/02/2012. The mechanism of injury was not stated. Current diagnoses include lumbar radiculitis, lumbago, lumbar sprain/strain and left hip bursitis/tendinitis. The injured worker was evaluated on 09/16/2013. The injured worker reported persistent lower back pain with radiation to the left lower extremity and constant left hip pain. Physical examination revealed limited lumbar range of motion, hypertonicity, positive straight leg raising on the left, decreased sensation at the L5-S1 dermatome, and decreased left hip range of motion. Treatment recommendations included continuation of current medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SOMNICIN #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) CHRONIC PAIN CHAPTER, INSOMNIA TREATMENT.

**Decision rationale:** The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Empirically supported treatment includes stimulus control, progressive muscle relaxation and paradoxical intention. The injured worker was also issued a prescription for Somnicin in 08/2013. There is no documentation of chronic insomnia or sleep disturbance. There is no evidence of a failure to respond to non-pharmacologic treatment. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

**GENICIN #90 CAPSULES:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

**Decision rationale:** The MTUS Chronic Pain Guidelines state glucosamine is recommended as an option given the low risk in patients with moderate arthritis pain. The injured worker does not maintain a diagnosis of osteoarthritis. The injured worker was also issued a prescription for Genicin in 08/2013. The injured worker continues to report persistent pain. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.