MAXIMUS Federal Services

Case Number:	CM13-0034859		
Date Assigned:	12/18/2013	Date of Injury:	07/18/2005
Decision Date:	04/21/2014	UR Denial Date:	09/25/2013
Priority:	Standard	Application Received:	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 Family Practice 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 patient is a 69-year-old female who reported an injury on 07/18/2005. The mechanism of injury occurred when the patient was lifting boxes at work. Review of the most recent clinical note dated 10/15/2013 revealed the patient has diagnoses of probable left thoracic outlet syndrome, left shoulder impingement syndrome versus mild multidirectional instability; improving right shoulder impingement syndrome, possible left carpal tunnel syndrome, and/or cubital tunnel syndrome; obesity; and lumbosacral strain. The patient continues to have complaints of numbness in her left upper extremity with less intensity. She complains of intermittent right shoulder and low back pain. She states that her left shoulder pain occurs intermittently, and is her greatest complaint. Objective findings upon examination revealed paresthesia with palpation in the subscapularis region of the left upper extremity and anterior scalene region. Special testing revealed positive Adson's test, positive Wright's test, and positive Roots test on the left. Examination of the left shoulder revealed diffuse tenderness with positive Hawkins test, positive Neer's test, negative apprehension, and negative relocation test. There is mention of an ultrasound of the bilateral upper extremities dated 08/21/2013 which revealed no evidence of upper extremity arterial stenosis. The patient was advised to continue home exercise program to prevent reconditioning.

IMR ISSUES, DECISIONS AND RATIONALES

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

TEROCIN LOTION: 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): 111-113.

Decision rationale: Per California MTUS Guidelines, it is stated that topical analgesics are largely experimental in use with few randomized controlled trials to determine the efficacy or safety of its use. They are generally recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The requested medication Terocin contains methyl Salicylate, menthol, Capsaicin, and Lidocaine hydrochloride compound. It is stated in California MTUS Guidelines that the only approved form of Lidocaine is a Lidoderm patch. It is also stated that Capsaicin is only recommended as there is documented failure to respond or intolerance to other treatments. As there is no documentation in the medical records suggestive that there has been any intolerance or lack of response to other treatments, and the medication contains Lidocaine HCl which is not recommended in this form, the medical necessity for continued use cannot be determined at this time and the request for Terocin lotion is non-certified.

GENICIN CAPSULES: 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 California MTUS Guidelines stated that glucosamine is recommended as an option given its low risk in patients with moderate arthritis pain, especially the knee osteoarthritis. As there is no documentation in the medical record suggestive that the patient has a diagnosis of osteoarthritis, the medical necessity for the use of the requested medication cannot be determined at this time. As such, the request for Genicin capsules is non-certified.

SOMNICIN CAPSULES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NON-MTUS

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

Decision rationale: California MTUS/ACOEM Guidelines do not address Somnicin or compound medications. Official Disability Guidelines state that compound medications are not recommended as a first line therapy for most patients but recommended as an option after a trial of first line FDA approved drugs has failed. The requested medication contains magnesium

oxide, melatonin, tryptophan, vitamin B6, and 5 hydroxytryptophan. It is noted that compounded medications combining 2 or 3 oral agents together are largely experimental, as there are no high quality medical studies found that support the efficacy or benefit over the individual agents separately. As there is no documentation in the medical record that the patient has had any attempts at failure of first line therapy to treat her condition, the medical necessity cannot be determined at this time. As such, the request for Somnicin is non-certified.

FLURBIPROFEN/LIDOCAINE/AMITRIPTYLINE: Upheld

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

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

Decision rationale: Per California MTUS Guidelines it is stated that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is also stated that any compound medication that includes a medication that is not recommended is not recommended. As California MTUS Guidelines state Lidocaine is only approved in the form of a Lidoderm patch, and there is no peer reviewed criteria to support the topical use of Amitryptiline or Flurbiprofen which is a non-steroidal anti-inflammatory agent. There is no documentation in the medical record of any failed attempts at the use of anticonvulsant medication or antidepressants to treat the patient's condition; therefore, the medical necessity for the requested service cannot be determined at this time. As such, the request for Flurbiprofen/Lidocaine/Amitryptiline is non-certified.

GABAPENTIN/CYCLOBENZAPRINE/TRAMADOL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is also stated that any compounded product that contains at least 1 drug that is not recommended is not recommended. The requested medication contains Tramadol which is not recommended as a first line oral analgesic. It also contains gabapentin which is not recommended as a topical analgesic, and there is no peer reviewed literature to support its use. Cyclobenzaprine is also not recommended as a topical analgesic, because there is no peer reviewed literature to support its use. As the requested medication contains 3 medications that are not recommended as topical analgesics, the medical necessity for continued use cannot be determined at this time. Therefore, the request for gabapentin/cyclobenzaprine/Tramadol is non-certified.