

Case Number:	CM13-0054527		
Date Assigned:	12/30/2013	Date of Injury:	11/13/2009
Decision Date:	06/05/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	11/19/2013

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 Orthopedic Surgery 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 68 year old female injured on 11/13/09 as a result of repetitive motions during routine job duties. Diagnoses included right knee internal derangement, right shoulder subacromial impingement with rotator cuff tear, right elbow traumatic lateral epicondylitis, right knee internal derangement, ligamentous low back sprain superimposed on lumbar multilevel degenerative disc disease, and left knee contusion. The patient underwent right total knee replacement on 11/28/11 and right shoulder arthroscopic intraarticular surgery with open rotator cuff repair on 06/20/11. Clinical note dated 10/18/13 indicated the patient reported increased pain in the right knee which caused the knee to give way and buckle. The patient reported right shoulder pain and persistent low back pain. The patient utilized a cane for ambulation. The documentation indicated utilization of topical compounds, oral medication, Terocin, gabacyclotram, and Flurbi for pain management. Urine Drug screening, MR arthrogram of the right shoulder, Terocin 240mg, Flurbi 180mg, Somnicin #30, Laxacin #100, and Gabacyclotram 180mg has been requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

URINE TOXICOLOGY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

Decision rationale: As noted on page 43 of the Chronic Pain Medical Treatment Guidelines, using a urine drug screen to assess for the use or the presence of illegal drugs is recommended as an option. However, there is no indication in the documentation that the patient is utilizing opioid medication or suspect for utilization of illegal drugs. As such, the request for urine toxicology cannot be recommended as medically necessary.

MR ARTHROGRAM OF THE RIGHT SHOULDER: 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-TWC), SHOULDER CHAPTER (LAST UPDATED 06/12/13), PROCEDURE SUMMARY, MR ARTHROGRAM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), - online version, Shoulder Disorders - Rotator Cuff Tendinopathies, MR Arthrogram.

Decision rationale: As noted in the Shoulder Disorders chapter of the American College of Occupational and Environmental Medicine (ACOEM), - online version, MR Arthrogram is recommended to diagnose rotator cuff tears. The patient previously underwent right shoulder arthroscopic intraarticular surgery with open rotator cuff repair on 06/20/11. There is no discussion in the documentation to establish the necessity of MR Arthrogram in the presence of previous rotator cuff repair. As such, the request for MR arthrogram of the right shoulder cannot be recommended as medically necessary at this time.

TEROCIN 240MG: Upheld

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

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Additionally, there is no indication that the patient cannot utilize a readily available over-the-counter formulation of this medication. Therefore this compound cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

FLURBI 180MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS,.

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore this compound cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

SOMNICIN #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MD CONSULT DRUG MONOGRAPH (LAST UPDATED 11/26/2011), MELATONIN.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Herbal medicines.

Decision rationale: As noted in the Pain chapter of the Official Disability Guidelines - Online version, the use of herbal medicines or medical foods is not recommended. Somnicin contains Melatonin 2 mg, 5-HTP (5-hydroxytryptophan) 50 mg, L-tryptophan 100 mg, Vitamin B6 (pyridoxine) 10 mg, and Magnesium 50 mg. There is no indication in the documentation that the patient has failed previous prescription medications or has obvious contraindications limiting use to medical foods. Additionally, there is no indication that the patient cannot utilize the over-the-counter version of this medication. As such, the request for Somnicin # 30 cannot be recommended as medically necessary.

LAXACIN #100: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation VETERANS HEALTH ADMINISTRATION DEPARTMENT OF DEFENSE. CLINICAL PRACTICE GUIDELINE, MANAGEMENT OF OPIOID THERAPY FOR CHRONIC PAIN.

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

Decision rationale: As noted on page Prophylactic treatment of constipation should be initiated. First-line treatment includes increased fluid intake, activity modification, and proper diet. Other over-the-counter medications can help loosen otherwise hard stools, add bulk, and increase water content of the stool. Second-line treatment includes the prescriptions Amitiza and Relistor. Laxacin is a combination of Docusate Sodium and Sennosides; both of which can be obtained over-the-counter. There is no indication in the documentation that the patient failed trials of first-line treatment of constipation. As such, the request for Laxacin #100 cannot be recommended as medically necessary.

GABACYCLOTRAM 180MG: Upheld

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

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore this compound cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.