

Case Number:	CM14-0001849		
Date Assigned:	01/22/2014	Date of Injury:	11/08/2000
Decision Date:	06/13/2014	UR Denial Date:	12/23/2013
Priority:	Standard	Application Received:	01/06/2014

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 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 injured worker is a 45 year old male who sustained an injury on 11/08/00. The mechanism of injury was not specifically discussed in the clinical records. The injured worker has been followed for chronic complaints of low back pain as well as pain in the bilateral feet, left side worse than right. The injured worker was seen on 11/07/13 with ongoing complaints of low back pain, bilateral feet pain, and difficulty with sleep due to pain. Medications at this visit did include Ativan as well as Norco 10/325mg for pain. On physical examination, the injured worker was overweight and ambulated with an antalgic gait favoring the left lower extremity. The injured worker was wearing orthotic shoes as well as inserts. There was obvious wear and tear to the shoes and a replacement was recommended. On physical examination, straight leg raise testing caused pain in the lower extremities bilaterally. There was tenderness to palpation throughout the lumbar spine with a noted muscle guarding. There was loss of lumbar range of motion present. In regards to the ankles and feet, there was limited range of motion noted bilaterally, right worse than left. At this visit, the injured worker was prescribed 2 topical compounded medications which included Flurbiprofen and Amitriptyline 180 grams as well as a compounded medication that contained Gabapentin, Cyclobenzaprine, and Tramadol 180 grams as well as Genicin 3 times daily. The requested wheelchair, topical compounded medications, and Genicin was denied by utilization review on 12/20/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTRIC WHEELCHAIR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES (2009), POWER MOBILITY DEVICES (PMDs), 99

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) KNEE & LEG CHAPTER, POWER MOBILITY DEVICE

Decision rationale: In regards to the request for an electric wheelchair, the clinical documentation provided for review did not contain any specific gait assessments or wheelchair assessments to support the use of an electric wheelchair over a standard wheelchair. There was no indication that the injured worker was unable to ambulate in any way, shape, or form that would require the use of a wheelchair. Per guidelines, there should be evidence to establish the injured worker is unable to propel a manual wheelchair in order to support the use of an electric wheelchair. As this assessment was not documented, this item is not indicated as medically necessary.

FLURBI (FLURBIPROFEN 20%/ LIDOCAINE 5%/ AMITRIPTYLINE 5%), APPLY 2 TO 3 TIMES A DAY, #180 GRAMS: 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): 111-113.

Decision rationale: In regards to the compounded medication that includes Flurbiprofen and Amitriptyline 180 grams, this reviewer would not have recommended this compounded medication as medically necessary. Per guidelines, the safety and efficacy of compounded medications have yet to be proven in peer reviewed literature or supported by any of the evidence based guidelines. Compounded medications are not recommended as 1st line therapy for most injured workers and should only be considered after a trial of 1st line FDA approved medications. The literature does not recommend multi-component compounded medications such as the use of Flurbiprofen and Amitriptyline. There is no indication from the clinical documentation that the patient is unable to tolerate oral medications or that oral medications are otherwise contraindicated. Furthermore, both Flurbiprofen and Amitriptyline are not FDA approved for transdermal use. Therefore, this compounded medication is not indicated as medically necessary.

GABACYCLOTRAM (GABAPENTIN 10%/ CYCLOBENZAPRINE 6%/ TRAMADOL 10%), APPLY 2 TO 3 TIMES A DAY, #180 GRAMS: 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): 111-113.

Decision rationale: In regards to the compounded medication that includes Gabapentin, Cyclobenzaprine, and Tramadol 180 grams, this reviewer would not have recommended this compounded medication as medically necessary. Per guidelines, the safety and efficacy of compounded medications have yet to be proven in peer reviewed literature or supported by any of the evidence based guidelines. Compounded medications are not recommended as 1st line therapy for most injured workers and should only be considered after a trial of 1st line FDA approved medications. The literature does not recommend multi-component compounded medications such as the use of Gabapentin, Cyclobenzaprine, and Tramadol. There is no indication from the clinical documentation that the patient is unable to tolerate oral medications or that oral medications are otherwise contraindicated. Furthermore, Gabapentin, Cyclobenzaprine, and Tramadol are not FDA approved for transdermal use. Therefore, this compounded medication is not indicated as medically necessary.

GENICIN 500MG, 1 CAPSULE THREE TIMES A DAY, UNKNOWN QUANTITY:
Upheld

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

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

Decision rationale: In regards to Genicin 500mg, this reviewer would not have recommended this medication as medically necessary. Genicin is a form of Glucosamine. Per guidelines, Glucosamine can be considered an option in the treatment of symptomatic osteoarthritis particularly in the knee. From the clinical documentation submitted for review, there is no evidence to establish any symptomatic osteoarthritis that would reasonably benefit from this medication. Therefore, Genicin is not indicated as medically necessary.