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| <b>Case Number:</b>   | CM14-0007530 |                              |            |
| <b>Date Assigned:</b> | 02/10/2014   | <b>Date of Injury:</b>       | 02/08/2006 |
| <b>Decision Date:</b> | 08/13/2014   | <b>UR Denial Date:</b>       | 12/28/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/21/2014 |

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 50-year-old male who has submitted a claim for failed back syndrome, radiculopathy of lumbosacral region, chronic post-op pain and joint pain of the shoulder associated with an industrial injury date of 2/8/2006. Medical records from 2012-2013 were reviewed which revealed constant low back pain and numbness of his extremities. His pain was graded 7/10. Aggravating factors include, increased activity and sitting a long time. Taking medications and rest relieved pain. Current medication regimen reduced his pain level to a tolerable level. Overall functionality improvement was approximately 40-50%. Physical examination of lumbar spine showed pain with extension and flexion. There was tenderness noted over paralumbar extensors. Range of motion was limited due to stiffness and pain. Straight leg raise test was equivocal bilaterally. Manual muscle testing of bilateral lower extremities was 5/5. Treatment to date has included, intake of medications namely; Cymbalta, Omeprazole, Lyrica and Suboxone. Utilization review from 12/27/2013 denied the retrospective request for Genicin and Somnicin because there was no clear detail provided from the available documentation of the necessity of both medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE MEDICATIONS GENICIN, (DURATION UNKNOWN AND FREQUENCY UNKNOWN) FOR TREATMENT OF NECK, LUMBAR, SPINE, RIGHT SHOULDER AND WRIST:** Upheld

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

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

**Decision rationale:** As stated on page 50 of California MTUS Chronic Pain Medical Treatment Guidelines, Glucosamine is recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. In this case, patient was prescribed Genicin, a brand name of Glucosamine. However, there was no documentation that the patient has arthritic pain that warrants its use. Furthermore, request did not indicate the quantity and duration of use of Genicin. However, request did not mention the quantity to be dispensed and the duration of use. The request is incomplete. Therefore, retrospective Genicin (duration unknown and frequency unknown) for treatment of neck, lumbar, spine, right shoulder and wrist is not medically necessary.