MAXIMUS Federal Services

Case Number:	CM14-0106863		
Date Assigned:	08/08/2014	Date of Injury:	09/22/2010
Decision Date:	10/07/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/10/2014

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 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 58 year old male who sustained an injury on 09/22/10 due to cumulative trauma while operating a bicycle. The injured worker has been followed for complaints of right foot and hip pain as well as psychological complaints. The injured worker has previously undergone physical therapy. Prior urine drug screen were negative for all substances testing. The injured worker was seen on 03/13/14. This was a handwritten report that was difficult to interpret due to handwriting and copy quality. The injured worker's physical exam findings noted tenderness to palpation in the right foot with loss of range of motion. The injured worker was evaluated for psychological complaints in April of 2014. The requested medications were all denied by utilization review on 06/27/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin Lotion 240mg DOS: 02/14/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine, Topical.

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

Decision rationale: The requested medication would not be supported as medically necessary in this case. The injured worker's last evaluation was from March of 2014 and did not provide any specifics regarding this medication or a rationale regarding ongoing medication use. No further evaluations were provided to further support ongoing medication use. Given the paucity of clinical information to support this medication, this reviewer would not have recommended the request as medically necessary.

Somnicin #30 (Unspecified Dosage) DOS: 02/14/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The requested medication would not be supported as medically necessary in this case. The injured worker's last evaluation was from March of 2014 and did not provide any specifics regarding this medication or a rationale regarding ongoing medication use. No further evaluations were provided to further support ongoing medication use. Given the paucity of clinical information to support this medication, this reviewer would not have recommended the request as medically necessary.

Genecin 500mg #90 DOS: 02/14/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The requested medication would not be supported as medically necessary in this case. The injured worker's last evaluation was from March of 2014 and did not provide any specifics regarding this medication or a rationale regarding ongoing medication use. No further evaluations were provided to further support ongoing medication use. Given the paucity of clinical information to support this medication, this reviewer would not have recommended the request as medically necessary.

Laxacin #100 (Unspecified Dosage) DOS: 02/14/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Laxacin. (2013).

Decision rationale: The requested medication would not be supported as medically necessary in this case. The injured worker's last evaluation was from March of 2014 and did not provide any specifics regarding this medication or a rationale regarding ongoing medication use. No further evaluations were provided to further support ongoing medication use. Given the paucity of clinical information to support this medication, this reviewer would not have recommended the request as medically necessary.

Ketoprofen 180mg DOS: 02/14/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA (Carisoprodol)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: The requested medication would not be supported as medically necessary in this case. The injured worker's last evaluation was from March of 2014 and did not provide any specifics regarding this medication or a rationale regarding ongoing medication use. No further evaluations were provided to further support ongoing medication use. Given the paucity of clinical information to support this medication, this reviewer would not have recommended the request as medically necessary.

Ketoprofen/Gabapentin/Cyclobenzaprine 6/20/4%, 180mg DOS: 02/14/2014: 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: The requested medication would not be supported as medically necessary in this case. The injured worker's last evaluation was from March of 2014 and did not provide any specifics regarding this medication or a rationale regarding ongoing medication use. No further evaluations were provided to further support ongoing medication use. Given the paucity of clinical information to support this medication, this reviewer would not have recommended the request as medically necessary.