

Case Number:	CM14-0130673		
Date Assigned:	08/20/2014	Date of Injury:	08/02/2012
Decision Date:	09/23/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/15/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 59 year old male with a reported date of injury on 08/02/2012. The mechanism of injury was not provided. The injured worker's diagnoses included cervical spine sprain with possible disc protrusion, right hand/finger injury, and right wrist fracture of the radius on 08/03/2012, right shoulder internal derangement, right elbow/forearm internal derangement, and triangular fibrocartilage complex tear. The injured worker's past treatments included medications, physical therapy, TENS therapy, paraffin wax hand therapy, wrist brace, occupational therapy, cold therapy, bone stimulator, and right arm sling. The injured worker underwent an MRI of the right wrist on 07/16/2013 and multiple right wrist x-rays on multiple dates. The injured worker's surgical history included right radius closed reduction and percutaneous pinning with K wires, right wrist ulna closed reduction under fluoroscopy in August 2012, and a right wrist block on 10/16/2012. A urine drug screen collected on 03/20/2014 was negative for benzodiazepines which was inconsistent with Alprazolam use and positive for marijuana (THC). The injured worker was evaluated on 05/15/2014 and reported occasional right shoulder pain rated at 2/10, occasional right elbow pain rated at 2/10, constant right wrist/hand pain with numbness rated at 3-4/10, pain without medication was rated 4/10, and pain with medication rated 0/10. The injured worker denied gastrointestinal side effects with medications and indicated topical medication allowed him to increase chores, sleep and decreased pain. The injured worker was evaluated on 05/20/2014 and complained of right wrist, and hand and finger pain. The clinician observed and reported a positive Soto-Hall test and decreased right hand/wrist/finger range of motion with pain (especially flexion). The injured worker's medications included Somnicin to be taken as directed for the treatment of insomnia, anxiety and muscle relaxation, Ganicin to be taken as directed for the treatment of arthritic pain,

Gabacyclotram 180mg applied in a thin layer to affected area 2-3 times per day as needed for treatment of pain and inflammation, Flurbi (NAP) Cream-LA 180 Gms apply a thin layer to affected area 2-3 times per day as needed for the treatment of pain and inflammation, and Terocin 120 ml apply a thin layer to affected area 3-4 times per day, Terocin Pain Patch as directed for the treatment of minor aches and muscle pains, Alprazolam, Hydrocodone/Acetaminophen 10/325 mg, Naproxen 500 mg, and Omeprazole. The physician was requesting Ganicin #90 capsule for the treatment of arthritic pain and Xolindo 2% cream for which no rationale was given. No request for authorization form was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ganicin #90 capsule (glucosamine): 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), Pain chapter.

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

Decision rationale: The injured worker was surgically treated for a right wrist injury in August of 2012. The MTUS Guidelines recommend glucosamine sulfate as an option in patients with moderate arthritis pain, especially for knee osteoarthritis. A documented diagnosis of osteoarthritis was not indicated. In addition, no strength, frequency or dosing instructions were provided in the request for Ganicin. Therefore, the request for Ganicin #90 capsule (glucosamine) was not medically necessary.

Xolindo 2% cream (lidocaine): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112.

Decision rationale: The injured worker was surgically treated for a right wrist injury in August of 2012. The MTUS Guidelines recommend topical lidocaine, in the formulation of a dermal patch for neuropathic pain and do not recommend topical lidocaine in any other formulation (including creams, lotions, and gels). The injured worker does not have a diagnosis of neuropathic pain. The guidelines do not recommend the use of Lidocaine for topical application in forms other than Lidoderm. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which the medication is to be applied in order to determine the necessity of the medication. The request for Xolindo 2% cream was not medically necessary.

