

Case Number:	CM14-0163498		
Date Assigned:	10/24/2014	Date of Injury:	05/15/2003
Decision Date:	12/03/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	10/06/2014

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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 51 year old male who sustained an industrial injury on 05/15/2003. The mechanism of injury was not provided for review. His diagnoses include left elbow pain, right knee pain, and right shoulder pain. On physical exam the left shoulder movements are restricted due to pain with tenderness in the acromioclavicular joint, greater tubercle of the humerus and axilla, and the rhomboid area. There is tenderness over the incision line of the left elbow with numbness and tingling distal to the scar. The right knee has decreased range of motion with flexion and extension. Treatment has included medical therapy, arthroscopic surgery chiropractic care and referral for joint/bursa injections. The treating provider has requested Hydrocodone/Acetaminophen 5/325, Somnicin capsule 2-50-100-10-50 mg, Speedgel, Lidoderm patch 5%, Neurontin 100mg, Mobic 15mg, Percura Capsules 35.2-10.2-35.2mg, and Terocin Cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone-Acetaminophen 5/325mg, unknown quantity: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 80, 81, 92.

Decision rationale: There is no documentation provided necessitating the use of Hydrocodone/APAP 10/325 for the claimant's chronic pain condition. The literature indicates that in chronic pain analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. Opioid therapy for pain control should not exceed a period of 2 weeks and should be reserved for moderate to severe pain. The failure to respond to a time limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no documentation from the provider indicating a specific clinical rationale for the requested medication. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Somnicin capsule 2-50-100-10-50 mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://skylerholdings.com/somnicin%E2%84%A2/lastupdated09/02/2012>

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, Insomnia Treatment

Decision rationale: This medication is noted as medical food in the medical food class, which Official Disability Guidelines indicate, "Is a food which is formulated to be consumed orally administered internally under the supervision of a physician in which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements based on recognized scientific principles are established by medical evaluation. There is no documentation of insomnia or any other sleep pathology. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

SpeedGel: Upheld

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

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: Medscape Internal Medicine 2013- Topical Anti-Inflammatory Medications

Decision rationale: SpeedGel Rx is a prescription homeopathic topical analgesic gel that provides relief of pain and inflammation utilizing a patented Isopiestic transdermal technology. The patient is tolerating oral anti-inflammatory medication. There is no specific indication for the requested item. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Lidoderm patch 5%: Upheld

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

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

Decision rationale: There is no documentation provided necessitating use of the requested Lidoderm Patch 5%. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, Capsaicin, local anesthetics, antidepressants, Glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosines, Cannabinoids, Cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating the use of Lidocaine patches. Per California MTUS 2009 Guidelines Lidoderm is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an anticonvulsant medication such as Gabapentin or Lyrica. The medication is only FDA approved for post-herpetic neuralgia. There is no documentation of intolerance to other previous treatments. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

Neurontin 100mg: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Medications Page(s): 13.

Decision rationale: The recommended medication, Neurontin is medically necessary for the treatment of the patient's condition. Per the documentation the claimant has neuropathic pain. The medication is part of his medical regimen and per California MTUS Guidelines 2009 anti-epilepsy medications are a first line treatment for neuropathic pain. A recommended trial period for an adequate trial of Gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. The patient has been prescribed the medication and the medical record documents a positive response. Medical necessity has been documented and the requested treatment is medically necessary for treatment of the patient's chronic pain condition.

Mobic 15mg: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-70.

Decision rationale: The review of the medical documentation indicates the patient requires Mobic therapy for his chronic pain condition. NSAIDs such as Mobic are the traditional first line of treatment to reduce pain so activity and functional restoration can resume. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of musculoskeletal pain concludes that available evidence supports the effectiveness of non-selective nonsteroidal anti-inflammatory drugs in chronic low back pain. There are no reports in the patient's medical documentation of GI intolerance to Mobic therapy. Because the patient has a chronic pain condition, medical necessity is established for Mobic at this time. The requested treatment is medically necessary.

Percura Capsules 35.2-10.2-35.2mg: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medscape Internal Medicine 2013: Percura

Decision rationale: Percura is a medical food product indicated for clinical dietary management of the metabolic processes of pain, inflammation and loss of sensation due to peripheral neuropathy. The claimant has neuropathic pain and is maintained on Neurontin therapy. There is no specific indication for the requested dietary supplement. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Terocin Cream: 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: Percura is a medical food product indicated for clinical dietary management of the metabolic processes of pain, inflammation and loss of sensation due to peripheral neuropathy. The claimant has neuropathic pain and is maintained on Neurontin therapy. There is no specific indication for the requested dietary supplement. Medical necessity for the requested item has not been established. The requested item is not medically necessary.