

Case Number:	CM14-0167580		
Date Assigned:	10/14/2014	Date of Injury:	02/10/2010
Decision Date:	11/17/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/10/2014

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 Internal Medicine and is licensed to practice in California. 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 52 year old male who was injured on 02/16/2013 due to a cumulative trauma. According to the UR, the patient was seen on 02/19/2013. This note is not available for review. He has a diagnosis of erectile dysfunction, decreased libido, back pain, benign prostatic hyperplasia, obesity, and hypertension. There are no updated notes provided for review. There is no history providing functional improvement with the requested medications. Prior utilization review dated 09/26/2014 states the request for Terocin Lotion #240 (Retrospective Dos 2/19/13); Somnicin #30 (Retrospective Dos 2/19/13) Genicin 500mg #90 (Retrospective Dos 2/19/13; Laxacin #100 (Retrospective Dos 2/19/13); Ketoprofen (Nap) Cream #180 (Retrospective Dos 2/19/13); and Ketogabacyclo #180 (Retrospective Dos 2/19/13) are denied as there is a lack of documented evidence to support the request

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin Lotion #240 (Retrospective Dos 2/19/13): 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 guidelines state that topical analgesics are largely experimental and are primarily used for neuropathic pain after a trial of first line medications. The guidelines state that any compounded product that contains at least one drug or drug class that is not recommended renders the entire medication to be not recommended. Terocin is a combination of lidocaine, capsaicin, methyl salicylate, and menthol. Menthol is not recommended for topical use by the current literature. There have been insufficient studies that have shown a benefit to topical menthol. Additionally, the request did not indicate a frequency of administration. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

Somnicin #30 (Retrospective Dos 2/19/13): 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, Medical Food

Decision rationale: CA MTUS is silent regarding the request. The ODG guidelines states: Medical Food: "a food which is formulated to be consumed or administered internally under the supervision of a physician and 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 documented food or nutritional deficiency in this case. There is no documentation that has shown a deficiency that requires these foods. Therefore the medical necessity for Somnicin #30 has not been established based on guidelines and lack of documentation.

Genicin 500mg #90 (Retrospective Dos 2/19/13): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine(and Chondroitin Sulfate).

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

Decision rationale: This is glucosamine. There is no diagnosis or evidence of degenerative joint disease of the knee. California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines provides limited support for glucosamine in knee osteoarthritis only. Primary treating physician has not provided medical rationale for this prescription. Therefore the medical necessity for Genicin 500 mg has not been established based on guidelines and lack of documentation.

Laxacin #100 (Retrospective Dos 2/19/13): 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: www.dailymed.nlm.nih.gov

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) and ODG is silent about laxatives/stool softener. This medication is for treatment of constipation. In order to authorize specific treatment methods, there must be sufficient documentation of medical necessity consistent with California Medical Treatment Utilization Schedule (MTUS) and evidence-based treatment guidelines. Primary treating physician has not provided medical necessity for this medication. Therefore the medical necessity of Laxacin #100 has not been established based on guidelines and lack of documentation.

Ketoprofen (Nap) Cream #180 (Retrospective Dos 2/19/13): 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 guidelines state that topical analgesics are largely experimental and are primarily used for neuropathic pain after a trial of first line medications. The guidelines state that any compounded product that contains at least one drug or drug class that is not recommended renders the entire medication to be not recommended. There was a lack of documentation that the patient has adequately tried and failed first line medications. A frequency of use for the request was not provided. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

Ketogabaclo #180 (Retrospective Dos 2/19/13): 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: California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic Pain, page 111 states " Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS Chronic Pain Guidelines do not support ketoprofen, gabapentin, and Cyclobenzaprine as topical medications. Therefore the request Ketogabaclo #180 (Retrospective Dos 2/19/13) is not medically necessary.