MAXIMUS Federal Services

Case Number:	CM14-0045935		
Date Assigned:	07/02/2014	Date of Injury:	03/22/1999
Decision Date:	08/18/2014	UR Denial Date:	03/20/2014
Priority:	Standard	Application Received:	04/14/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 42-year-old male who reported an injury on 03/31/2013. The mechanism of injury was not stated. Current diagnoses include lumbar spine sprain/strain with left lower extremity radiculitis, left hip strain/sprain, and right acetabulum fracture. The latest Physician's Progress Report submitted for this review is documented on 05/13/2014. The injured worker presented with an improvement in symptoms following injection therapy. Physical examination revealed positive trigger points with tightness, limited lumbar range of motion, positive Kemp's testing, positive Yeoman's test, and positive Gaenslen's test. Treatment recommendations included continuation of a home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patch, Qty 30: Upheld

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

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

Decision rationale: The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no strength or frequency listed in the current request. Therefore, the request for Terocin patch, Qty: 30 is not medically necessary.

Somnicin, Qty 30: Upheld

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

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

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. There is no documentation of insomnia or sleep disturbance. There is no strength or frequency listed in the current request. Based on the clinical information received, the request for Somnicin, Qty: 30 is not medically necessary.

Gabacyclotram, Qty 1: Upheld

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

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

Decision rationale: The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Gabapentin is not recommended, as there is no evidence for the use of an anticonvulsant as a topical product. Cyclobenzaprine is also not recommended. There is no frequency or strength listed in the current request. As such, the request for Gabacyclotram, Qty 1 is not medically necessary.

Flurbiprofen (NAP) cream, Qty 1: Upheld

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

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

Decision rationale: The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The

only FDA approved topical NSAID is Diclofenac. Therefore, the current request cannot be determined as medically appropriate. As such, the request for Flurbiprofen (NAP) cream, Qty 1 is not medically necessary.