

Case Number:	CM14-0087726		
Date Assigned:	07/23/2014	Date of Injury:	07/12/2004
Decision Date:	09/10/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/11/2014

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 Florida. 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 62-year-old female who reported an injury on 07/12/2004 after being struck by a mirror of a moving vehicle walking down the road. The injured worker had a history of lower back pain to the right sacroiliac area and pain to the upper extremities. The injured worker had diagnoses of cervical strain, cervical radiculopathy, cervical disco genic disease, right ankle strain, and a left shoulder rotator cuff tear. The past diagnostics included an EEG study in 2004, electro diagnostic evidence of mild bilateral carpal tunnel syndrome. The MRI of unknown date revealed cervical disc prolapse at the C5-6 measuring 3 mm with spinal stenosis. The past treatments included physical therapy. The pertinent surgical history included a postop right facial area, status post-surgical intervention to the left shoulder region, and status post injury to the right arm. The Request for Authorization was not submitted with documentation. The rationale for the topical creams and the Somnicin capsules was not provided. The medications included Vicodin, Pamelor 25 mg, Kelan 120 mg, Maxalt 10 mg, Imitrex 100 mg, and Feldene. No VAS provided and treatment plan unclear. The Request for Authorization was not submitted with documentation. The rationale for the creams was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective review of Somnicin capsule DOS 1/16/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine, Official Disability Guidelines.

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

Decision rationale: The request for Somnicin # 30 dispensed on 11/20/13 is not medically necessary. The Official Disability Guidelines criteria for medical food indicate a food which is formulated to be consumed or administered entirely 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. To be considered the product must, at a minimum, meet the following criteria. The product must be a food for oral or tube feeding. This drug/medical food is not medically necessary. The clinical notes provided do not support the use of this request. The request did not address the frequency, dosage or route. As such, the request is not medically necessary.

Retrospective review of Flurbiprofen/Lidocaine/amitriptyline DOS 1/16/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Topical Analgesic, NSAIDS.

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

Decision rationale: The request for Retrospective review of Flubiprofen/ Lidocaine/ Amitriptyline DOS 01/16/2014 is not medically necessary. The CA MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety; also, that they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally 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; however, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended, therefore, is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The physical examination was vague with the findings. The guidelines do not recommend compound agents. The request did not address the frequency, dosage or duration. As such, the request is not medically necessary.

Retrospective review of Gabapentin/ Cyclobenzaprine/Tramadol DOS 1/16/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Topical analgesics, NSAIDS.

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

Decision rationale: The request for Gabapentin/Cyclobenzaprine/ Tramadol DOS 01/16/2014 is not medically necessary. The CA MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety; also, that they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally 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; however, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended, therefore, is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Per the guidelines Gabapentin is not recommended. There is no peer-reviewed literature to support use. The physical examination was vague with the findings. The guidelines do not recommend compound agents. The request did not address the frequency, dosage or duration. As such, the request is not medically necessary.