

Case Number:	CM15-0108273		
Date Assigned:	06/12/2015	Date of Injury:	08/21/2014
Decision Date:	09/23/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	06/04/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York, West Virginia, Pennsylvania
 Certification(s)/Specialty: Emergency Medicine

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 52 year old male, who sustained an industrial injury on 8/21/14. The injured worker has complaints of numbness and tingling into thumb, index and long of both hands, right more than left. The documentation noted that right shoulder pain is increased with repetitive use especially with reaches. The documentation noted that the injured worker had marked tenderness in the subacromial area. The diagnoses have included impingement syndrome with partial rotator cuff; lateral epicondylitis of the right elbow with injury to the median nerve and right hand sprain/strain with middle finger tendonitis. Treatment to date has included therapy; activity restrictions; non-steroidal anti-inflammatories; bracing; cortisone injections in the shoulder and nerve testing of the upper extremities and was seen to have impingement with partial tearing of the rotator tendon and slowing with conduction velocity test. The request was for Somnicin capsule #30 date of service 3/13/15; gabapentin 10%, cyclobenzaprine 6%, tramadol 10%, Lidoderm base 180gm date of service 3/13/15; Terocin lotion date of service 3/13/15; Genicin 500mg capsule #90 date of service 3/13/15 and Flurbiprofen powder/lidocaine HCL powder/Amitriptyline HCL powder/PCCA Lidoderm base 180gm date of service 3/13/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Somnicin capsule #30 DOS: 3/13/15: 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 <http://skylerholdings.com/somnicin>.

Decision rationale: Guidelines do not support use of Somnicin for treatment of insomnia since it is a supplement and is not FDA approved to treat any medical condition and several ingredients contained in Somnicin are not recommended by guidelines. The request for Somnicin #30 is not medically appropriate and necessary.

Gabapentin 10% Cyclobenzaprine 6% Tramadol 10% Lipoderm Base 180gm DOS: 3/13/15: Upheld

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

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

Decision rationale: Guidelines state that topical agents are largely experimental and primarily recommended for neuropathic pain when trials of antidepressants and antiepileptics have failed. Any compounded product that contains at least one drug that is not recommended is not recommended. In this case, there was no evidence of failure of all other first line drugs and there is no evidence to support use of any muscle relaxant as a topical product. The request for topical gabapentin/cyclobenzaprine/tramadol is not medically appropriate and necessary.

Terocin lotion DOS: 3/13/15: Upheld

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

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

Decision rationale: Guidelines state that topical agents are largely experimental and primarily recommended for neuropathic pain when trials of antidepressants and antiepileptics have failed. Any compounded product that contains at least one drug that is not recommended is not recommended. In this case, lidocaine is not approved for neuropathic pain. The request for topical Terocin is not medically appropriate and necessary.

Genicin 500mg capsule #90 DOS: 3/13/15: Upheld

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

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

Decision rationale: Guidelines recommend Genicin for treatment of moderate arthritis pain and should be continued as long as functional benefit or reduction in work restrictions results. In this case, there is no documentation of moderate arthritis pain or documentation of functional benefit or improvement. The request for Genicin 500 mg #90 is not medically necessary and appropriate.

Flurbiprofen powder/Lidocaine HCL powder/Amitriptyline HCL powder/PCCA Lipoderm base 180gm DOS: 3/13/15: Upheld

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

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

Decision rationale: Guidelines state that topical agents are largely experimental and primarily recommended for neuropathic pain when trials of antidepressants and antiepileptics have failed. Any compounded product that contains at least one drug that is not recommended is not recommended. In this case, guidelines do not recommend topical use of lidocaine. The request for topical Flurbiprofen/lidocaine/Amitriptyline is not medically appropriate and necessary.