

Case Number:	CM15-0144004		
Date Assigned:	08/04/2015	Date of Injury:	09/17/2014
Decision Date:	09/22/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/24/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 28-year-old male, who sustained an industrial injury on 9-17-14. He has reported initial complaints of twisting his right ankle and falling getting out of a truck. The diagnoses have included headache, right hip sprain and strain, status post right knee surgery, right ankle sprain and strain, anxiety, depression and stress. Treatment to date has included medications, diagnostics, activity modifications, right knee surgery, physical therapy and crutches. Currently, as per the physician initial comprehensive evaluation progress note dated 4-9-15, the injured worker complains of headaches and pain in the right hip and right knee. He also experiences anxiety, depression and insomnia due to pain. The right hip pain radiates to the right knee and is rated 8 out of 10 on the pain scale with numbness and tingling in the right leg. The right knee pain radiates to the right hip with clicking in the right knee. The knee pain is rated 10 out of 10 on the pain scale. He also has right knee swelling at times with giving-way of the right knee. The current medications included Oxycodone. There is no previous urine drug screen reports noted. The physical exam reveals tenderness and spasm over the right gluteus muscle. The hip range of motion is decreased with flexion external rotation and abduction. There is positive patellar grinding of the right knee and the right knee range of motion is decreased with flexion at 130 degrees. The right ankle range of motion is decreased in all planes. There is decreased sensation to light touch in the right lower extremity (RLE). The physician requested treatments included Genicin #90, Somnicin #30, Flurbi NAP Cream LA 180 grams, Gabacyclotram 180 grams, Terocin 240ml, and Capsaicin 0.025%.

IMR ISSUES, DECISIONS AND RATIONALES

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

Genicin #90: Overturned

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

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

Decision rationale: The patient presents on 04/09/15 with intermittent headaches, right hip pain rated 8/10 which radiates into the right knee, right knee pain rated 10/10, and associated depression and insomnia secondary to pain and loss of function. The patient's date of injury is 09/17/14. Patient is status post arthroscopic right knee surgery on 01/26/15. The request is for GENICIN #90. The RFA was not provided. Physical examination dated 04/09/15 reveals tenderness to palpation and spasm in the right gluteal muscles, reduced right hip range of motion in all planes, positive patellar grinding in the right knee with reduced range of motion noted, tenderness in the right lateral ankle with reduced right ankle range of motion noted. Neurological examination reveals decreased sensation to light touch along the L4 and L5 dermatomal distributions. The patient is currently prescribed Oxycodone. Patient is currently classified as temporarily totally disabled through 07/02/15. MTUS Chronic Pain Medical Treatment Guidelines, page 50 under Glucosamine (and Chondroitin Sulfate) states: "Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline glucosamine sulphate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride (GH)." In regard to Genicin, a nutritional supplement containing Glucosamine and Chondroitin, the request is appropriate. MTUS supports the use of Glucosamine in patients with moderate arthritis pain. It does not appear that this patient has been prescribed Genicin to date. This patient presents with arthritic complaints in the right hip and right knee, such nutritional supplementation is supported by guidelines for complaints of this nature. Therefore, the request IS medically necessary.

Somnicin #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain.

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 under Somnicin.

Decision rationale: The patient presents on 04/09/15 with intermittent headaches, right hip pain rated 8/10 which radiates into the right knee, right knee pain rated 10/10, and associated depression and insomnia secondary to pain and loss of function. The patient's date of injury is 09/17/14. Patient is status post arthroscopic right knee surgery on 01/26/15. The request is for SOMNICIN #30. The RFA was not provided. Physical examination dated 04/09/15 reveals tenderness to palpation and spasm in the right gluteal muscles, reduced right hip range of motion in all planes, positive patellar grinding in the right knee with reduced range of motion noted,

tenderness in the right lateral ankle with reduced right ankle range of motion noted. Neurological examination reveals decreased sensation to light touch along the L4 and L5 dermatomal distributions. Patient is currently classified as temporarily totally disabled through 07/02/15. The MTUS and ACOEM Guidelines do not address this request. However, ODG Guidelines under the Pain Chapter on Somnicin states, Not recommended. Somnicin, a nutritional supplement, contains melatonin, magnesium oxide, oxitriptan (the L form of 5-hydroxytryptophan), 5-hydroxytryptophan, tryptophan and Vitamin B6 (pyridoxine). It is postulated as a treatment for insomnia, anxiety and depression. Melatonin appears to reduce sleep onset latency and is used for delayed sleep phase syndrome. In regard to the request for Somnicin for this patient's sleep complaint secondary to chronic pain, this medication is not supported by guidelines. It is not clear how long this patient has been prescribed Somnicin or to what effect. Official disability guidelines do not support this medication at this time owing to a lack of clinical studies showing evidence for the efficacy of this particular formulation as a sleep aid. Therefore, the request IS NOT medically necessary.

Flurbi NAP Cream LA 180 grams: Upheld

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

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

Decision rationale: The patient presents on 04/09/15 with intermittent headaches, right hip pain rated 8/10 which radiates into the right knee, right knee pain rated 10/10, and associated depression and insomnia secondary to pain and loss of function. The patient's date of injury is 09/17/14. Patient is status post arthroscopic right knee surgery on 01/26/15. The request is for FLURBI NAP CREAM LA 180 GRAMS. The RFA was not provided. Physical examination dated 04/09/15 reveals tenderness to palpation and spasm in the right gluteal muscles, reduced right hip range of motion in all planes, positive patellar grinding in the right knee with reduced range of motion noted, tenderness in the right lateral ankle with reduced right ankle range of motion noted. Neurological examination reveals decreased sensation to light touch along the L4 and L5 dermatomal distributions. Patient is currently classified as temporarily totally disabled through 07/02/15. MTUS guidelines, pages 111 regarding Topical Lidocaine do not support any other formulation than topical patches. The MTUS guidelines do not support the use of topical NSAIDs such as Flurbiprofen for axial, spinal pain, but supports its use for peripheral joint arthritis and tendinitis. Regarding topical compounded creams on pg 111. guidelines stat that "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In regard to the Flurbi-Nap cream, the requested cream is not supported by MTUS guidelines. Flurbiprofen is only recommended for peripheral joint arthritis and tendinitis. In this case, there is no documentation of how the topical product is being used with what effectiveness. Only short-term use of topicals are recommended and the treater does not discuss this product for a short-term use. The request IS NOT medically necessary.

Gabacyclotram 180 grams: Upheld

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

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

Decision rationale: The patient presents on 04/09/15 with intermittent headaches, right hip pain rated 8/10 which radiates into the right knee, right knee pain rated 10/10, and associated depression and insomnia secondary to pain and loss of function. The patient's date of injury is 09/17/14. Patient is status post arthroscopic right knee surgery on 01/26/15. The request is for GABACYCLOTRAM 180 GRAMS. The RFA was not provided. Physical examination dated 04/09/15 reveals tenderness to palpation and spasm in the right gluteal muscles, reduced right hip range of motion in all planes, positive patellar grinding in the right knee with reduced range of motion noted, tenderness in the right lateral ankle with reduced right ankle range of motion noted. Neurological examination reveals decreased sensation to light touch along the L4 and L5 dermatomal distributions. Patient is currently classified as temporarily totally disabled through 07/02/15. MTUS guidelines on page 111, state that "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." Additionally, the guidelines state that there is no evidence for use of any muscle relaxants such as Cyclobenzaprine as a topical product. MTUS Guidelines also provide clear discussion regarding topical compounded creams on pg 111. "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In regard to the Gabacyclotram cream, the requested topical cream is not supported by MTUS guidelines. This topical formulation contains Gabapentin and Cyclobenzaprine, which are not recommended by MTUS. MTUS Guidelines also provide clear discussion regarding topical compounded creams, indicating that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, this request IS NOT medically necessary.

Terocin 240ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical lidocaine Page(s): 112.

Decision rationale: The patient presents on 04/09/15 with intermittent headaches, right hip pain rated 8/10 which radiates into the right knee, right knee pain rated 10/10, and associated depression and insomnia secondary to pain and loss of function. The patient's date of injury is 09/17/14. Patient is status post arthroscopic right knee surgery on 01/26/15. The request is for TEROGIN 240ML. The RFA was not provided. Physical examination dated 04/09/15 reveals tenderness to palpation and spasm in the right gluteal muscles, reduced right hip range of motion in all planes, positive patellar grinding in the right knee with reduced range of motion noted, tenderness in the right lateral ankle with reduced right ankle range of motion noted. Neurological examination reveals decreased sensation to light touch along the L4 and L5 dermatomal distributions. Patient is currently classified as temporarily totally disabled through 07/02/15. The MTUS guidelines p112 on topical lidocaine states, "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." MTUS further states, "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In regard to the

request for Terocin Lotion, the provider does not document the area of treatment nor how the lotion will be used. The patient presents with right hip pain which radiates into the right knee, not with localized peripheral neuropathic pain amenable to Lidocaine. Furthermore, MTUS only supports Lidocaine in patch form, and specifically states that any formulation other than patches is not supported for use. Given these factors, the request cannot be substantiated. The request IS NOT medically necessary.

Capsaicin 0.025%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines capsaicin Page(s): 28-29.

Decision rationale: The patient presents on 04/09/15 with intermittent headaches, right hip pain rated 8/10 which radiates into the right knee, right knee pain rated 10/10, and associated depression and insomnia secondary to pain and loss of function. The patient's date of injury is 09/17/14. Patient is status post arthroscopic right knee surgery on 01/26/15. The request is for CAPSAICIN 0.025%. The RFA was not provided. Physical examination dated 04/09/15 reveals tenderness to palpation and spasm in the right gluteal muscles, reduced right hip range of motion in all planes, positive patellar grinding in the right knee with reduced range of motion noted, tenderness in the right lateral ankle with reduced right ankle range of motion noted. Neurological examination reveals decreased sensation to light touch along the L4 and L5 dermatomal distributions. Patient is currently classified as temporarily totally disabled through 07/02/15. MTUS Guidelines, pages 28-29 states: "Recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation as a treatment for osteoarthritis and a 0.075% formulation primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful -alone or in conjunction with other modalities- in patients whose pain has not been controlled successfully with conventional therapy." In regard to the request for Capsaicin cream for the management of this patient's intractable chronic pain, treater has not provided quantity of the requested cream or specified a location where it is to be applied. There is no indication in the records provided that this patient is intolerant to other treatments such as oral medications. Furthermore, the request as written does not specify a quantity to be provided to the patient, only the concentration of the active ingredient. Therefore, the request IS NOT medically necessary.