MAXIMUS Federal Services

Case Number:	CM15-0125350		
Date Assigned:	07/09/2015	Date of Injury:	10/02/2014
Decision Date:	08/05/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	06/29/2015

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 Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular 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:

This injured worker is a 47 year old female who reported an industrial injury on 10/2/2014. Her diagnoses, and or impressions, were noted to include: post-concussion syndrome; chronic pain; degeneration of cervical disc; cervical disc displacement without myelopathy; headache; and lumbar disc displacement without myelopathy. No current electrodiagnostic studies or imaging studies were noted. Her treatments were noted to include diagnostic studies; cervical facet radio-frequency ablation (5/12/15); ice therapy; trans-cutaneous electrical nerve stimulation unit therapy; medication management with toxicology screenings; and restricted work duties. The progress notes of 6/17/2015 reported complaints which included chronic, severe head and left-sided neck pain. Objective findings were noted to include tenderness, with guarding, along the left-sided cervical para-spinal muscles that were with tension into the left upper trapezius muscle; and decreased deep tendon reflexes at the biceps, triceps and brachioradialis. The physician's requests for treatments were noted to include the continuation of topical Capsaicin cream and oral Glucosamine Chondroitin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Capsaicin 0.075% cream (DOS 5/21/15) Qty: 2: Upheld

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

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

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The proposed topical analgesic contains capsaicin a topical analgesic not recommended by MTUS. There is no clear evidence that the patient failed or was intolerant to first line oral pain medications (antidepressant and anticonvulsant). Therefore, the request for Capsaicin 0.075% cream is not medically necessary.

Glucosamine-chondrotin 500-400mg Qty: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter and Low back chapter - Glucosamine.

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

Decision rationale: According to MTUS guidelines, Glucosamine is recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. There is no sufficient evidence to support the efficacy of glucosamine other than knee osteoarthrtitis. There is no clear evidence of knee osteoarthritis. Therefore, the request of Glucosamine-chondrotin 500-400mg Qty: 90 is not medically necessary.