

Case Number:	CM14-0144444		
Date Assigned:	09/12/2014	Date of Injury:	04/03/2007
Decision Date:	10/22/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	09/05/2014

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 and Rehabilitation and is licensed to practice in Texas. 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 43 year old male who reported an injury to his right shoulder and neck on April 3, 2007. The utilization review dated August 08, 2014 resulted in denials for the continued use of Soma, Ketoprofen powder, as well as Glucosamine. No objective findings were identified in the submitted documentation regarding any functional improvements regarding the injured worker's use of Glucosamine. The clinical note dated July 9, 2014 indicates the injured worker stated the initial injury occurred on February 15, 2007. The injured worker reported an exacerbation of neck pain at that time. The injured worker rated the pain as 9/10. Upon exam, the injured worker was able to demonstrate 35 degrees of cervical flexion with 30 degrees of extension, 40 degrees of right lateral rotation, 50 degrees of left lateral rotation, and 30 degrees of bilateral lateral flexion. The injured worker was being recommended for the use of Soma, Norco, Glucosamine, and Ketoprofen powder. The clinical note dated June 11, 2014 indicates the injured worker having been recommended for the use of Glucosamine, Norco, and Gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma). Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary last updated 06/10/2014

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 65.

Decision rationale: This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. The documentation indicates that the injured worker is being prescribed the medication for chronic pain and long-term care exceeding the recommended treatment window. Therefore, this request is not indicated.

Ketoprofen powder 10% cream #1: Upheld

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

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

Decision rationale: The safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore this compound cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Glucosamine/chondroitin 1500/400mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine and Chondroitin Sulfate.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: 1.) Kahan A, et al. Long-Term Effects of Chondroitins 4 and 6 Sulfate on Knee Osteoarthritis. Arthritis Rheum. 2009 Feb; 58(11):524-533. 2.) Jump up ^ Wildi LM, et al. Chondroitin sulphate reduces both cartilage volume loss and bone marrow lesions in knee osteoarthritis injured workers starting as early as 6 months after initiation of therapy: a randomised, double-blind, placebo-controlled pilot study us

Decision rationale: The request for Glucosamine is not medically necessary. The documentation indicates the injured worker complaining of neck pain. Glucosamine is indicated for findings consistent with osteoarthritis. No information was submitted regarding the injured

worker's confirmation of osteoarthritic findings. Therefore, this request is not indicated as medically necessary.