
Notice of Independent Medical Review Determination

Dated: 9/10/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/3/2013

12/17/1996

7/12/2013

CM13-0001365

- 1) MAXIMUS Federal Services, Inc. has determined the request for Theratramadol 50mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Sentraflox 10mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Sentrazolpidem 5mg **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/12/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/16/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for Theratramadol 50mg **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Sentraflox 10mg **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Sentrazolpidem 5mg **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 3, 2013

“History of Condition:

This is a 66-year-old female with a 12/17/1996 date of injury. A specific mechanism of injury has not been described. 6/7/13 progress report identifies that the patient returns essentially unchanged. She reports that medications are helpful. Objectively, gait remains guarded with allodynia bilaterally to the midcalf, right greater than left. Diagnostic impression Includes bilateral lower extremity complex regional pain syndrome, fibromyalgia.”

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review x3 (received 7/12/13)
- Utilization Review Determination from [REDACTED] (dated 7/3/13)
- Official Disability Guidelines (ODG) (updated 06/07/13), Pain Chapter, Theramine Section, Medical Food Section
- Medical Records from [REDACTED], MD (dated 3/1/13-6/11/13)

1) Regarding the request for Theratramadol 50mg:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines Pain Chapter, Theramine and Medical Food Sections, a medical treatment guideline (MTG) not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS applicable and relevant to the issue at dispute. The Expert Reviewer found the guidelines used by the Claims Administrator applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee was injured on 12/17/1996. The medical records submitted and reviewed reported left foot pain with sensitivity and right foot pain with sensitivity and discoloration. The employee's diagnoses include bilateral lower extremity complex regional pain syndrome and fibromyalgia. Treatment included multiple medications. A request was submitted for Theratramadol 50mg.

Official Disability Guidelines do not recommend the use of Theramine (a medical food) due to a lack of high quality studies. Approved medical food products "must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements". In this case, the clinical notes lack evidence of the employee presenting with any deficiencies which would require the requested medication. Furthermore, there is a lack of documentation to support the efficacy of this medication for the treatment of the employee's reported pain. The request for Theratramadol 50mg is not medically necessary and appropriate.

2) Regarding the request for Sentraflox 10mg:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines Pain Chapter, Theramine and Medical Food Sections, a medical treatment guideline (MTG) not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS applicable and relevant to the issue at dispute. The Expert Reviewer found the Official Disability Guidelines Pain Chapter, Medical Food Section, a medical treatment guideline (MTG) not part of the Medical Treatment Utilization Schedule (MTUS) applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee was injured on 12/17/1996. Medical records submitted and reviewed reported left foot pain with sensitivity and right foot pain with sensitivity and discoloration. The employee's diagnoses include bilateral lower extremity

complex regional pain syndrome and fibromyalgia. Treatment included multiple medications. A request was submitted for SentrafloX 10mg.

Official Disability Guidelines indicate that medical foods (Sentra) “must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements”. In this case, the medical records do not demonstrate that the employee presents with any deficiencies which require SentrafloX 10mg. Furthermore, there is a lack of documentation to support the efficacy of this medication for the treatment of the employee’s reported pain. The request for SentrafloX 10mg is not medically necessary and appropriate.

3) Regarding the request for Sentrazolpidem 5mg:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines Pain Chapter, Theramine Section, a medical treatment guideline (MTG) not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS applicable and relevant to the issue at dispute. The Expert Reviewer found the guidelines used by the Claims Administrator applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee was injured on 12/17/1996. Medical records submitted and reviewed reported left foot pain with sensitivity and right foot pain with sensitivity and discoloration. The employee’s diagnoses include bilateral lower extremity complex regional pain syndrome and fibromyalgia. Treatment included multiple medications. A request was submitted for Sentrazolpidem 5mg.

Official Disability Guidelines indicate that medical foods (Sentra) “must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements”. The medical records reviewed indicate the employee does not present with any deficiencies which would require the requested medication. Furthermore, there is a lack of documentation to support the efficacy of this medication for the treatment of the employee’s reported pain. The request for Sentrazolpidem 5mg is not medically necessary and appropriate.

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/srb

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.