

Independent Medical Review Final Determination Letter

2130
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/27/2013

IMR Case Number:	CM13-0021031	Date of Injury:	03/09/1999
Claims Number:	[REDACTED]	UR Denial Date:	08/09/2013
Priority:	STANDARD	Application Received:	09/06/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED] DR		
Treatment(s) in Dispute Listed on IMR Application:			
(NOT LEGIBLE)			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]
[REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology, has a subspecialty in Cardiovascular Disease 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 physician 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.

DOCUMENTS REVIEWED

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

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 67-year-old female with a reported date of injury of 03/09/1999. The clinical information submitted for review indicates subjective complaints of continued total body pain, chronic fatigue, problems sleeping and morning gel phenomenon. The patient was noted to be using a walker due to difficulty keeping balance. Objective findings in the documentation indicated no new joint swelling, normal neurological examination, and no rheumatoid arthritis deformities. The patient's diagnoses include myalgia and myositis, Raynaud's syndrome, and carpal tunnel syndrome. The treatment plan has included the use of Trepadone, Sentra AM, flurbiprofen, tramadol and flurbiprofen topical, gabapentin, Ultracet and omeprazole.

IMR DECISION(S) AND RATIONALE(S)

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

1. Sentra AM #60 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Pain, Medical Food, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The patient was injured on 03/09/1999 and presents with myalgia and myositis, Raynaud's syndrome, and carpal tunnel syndrome. The patient has been treated with oral and topical analgesic medications as well as oral medical foods. The most recent Primary Treating Physician's Progress Report dated 07/15/2013 indicated no new joint swelling, normal neurological examination, and no rheumatoid arthritis deformities. The patient was also noted to be using a walker. The provider recommended various topical compounds, medical foods, and oral analgesics. A request was submitted for Sentra AM #60 and Trepadone #90. The Official Disability Guidelines state that medical foods are not considered medically necessary, except in those cases in which the patient has a medical disorder, disease or condition for which there are distinctive nutritional requirements. The clinical information submitted for review does not include evidence that the patient's myalgia and myositis, Raynaud's syndrome, and carpal tunnel syndrome have any distinctive nutritional requirements. As such, the medical necessity of Sentra AM #60 has not been established.

2. Trepadone #90 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Pain, Medical Food, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The patient was injured on 03/09/1999 and presents with myalgia and myositis, Raynaud's syndrome and carpal tunnel syndrome. The patient has been treated with oral and topical analgesic medications as well as medical foods. The most recent Primary Treating Physician's Progress Report dated 07/15/2013 indicated no new joint swelling, normal neurological examination and no rheumatoid arthritis deformities. The patient was also noted to be using a walker. The provider recommended various topical compounds, medical foods and oral analgesics. A request was submitted for Sentra AM #60 and Trepadone #90. The Official Disability Guidelines state that medical foods are not considered medically necessary, except in those cases in which the patient has a medical disorder, disease or condition for which there are distinctive nutritional requirements. The clinical information submitted for review does not include evidence that the patient's myalgia and myositis, Raynaud's syndrome and carpal tunnel syndrome have any distinctive nutritional requirements. As such, the medical necessity of Trepadone #90 has not been established.

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.

[REDACTED]

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