

<b>Case Number:</b>	CM13-0021158		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	01/19/2006
<b>Decision Date:</b>	01/16/2014	<b>UR Denial Date:</b>	08/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2013

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California and 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. 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 patient is a 51-year-old female who reported an injury on October 14, 2005. The mechanism of injury was not provided for review. The patient underwent an MRI in February of 2011 that revealed a disc protrusion effacing the ventral thecal sac. The patient received biofeedback therapy. The patient's chronic low back pain was managed with medications and epidural steroid injections. The patient underwent a discogram that was mildly positive at the L3-4 level and strongly positive at the L4-5 level. The patient's medications included Tylenol when necessary for pain every 4 hours, Vicodin 5/500 mg at night, Cyclobenzaprine 7.5 mg daily at bedtime, and Zantac 150 mg daily. The patient's most recent physical exam findings revealed bilateral low back pain radiating into the lower extremities rated at 7/10, negative straight leg raising test bilaterally, positive facet provocation bilaterally with moderate tenderness and muscle spasms bilaterally at the L3-4, L4-5, and L5-S1. It is noted that the patient was complaining of insomnia. The patient's diagnoses included lumbosacral spondylosis, sacroiliitis, thoracic lumbosacral radiculopathy, lumbar disc displacement, and lumbosacral disc degeneration. The patient's treatment plan included Sentra at bedtime to assist with sleeping, Theramine 3 times a day for chronic pain and inflammation, discontinuation of NSAIDs due to severe gastritis, and continuation of muscle relaxants.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) prescription of Motrin 600mg.: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60.

**Decision rationale:** The requested Motrin 600 mg on August 15, 2013 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has continued pain complaints. It is noted within the documentation that the patient's medications received multiple changes at that visit. The patient's Vicodin was discontinued. It is also noted that the patient was taking Tylenol which was replaced with Motrin. The California MTUS recommends medication changes for a patient being treated with chronic pain is made one (1) medication at a time to establish the efficacy of each change. Therefore, multiple changes would not be supported. As such, the requested Motrin 600 mg between is not medically necessary or appropriate.

**One (1) prescription of Flexeril 7.5mg, #60.: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril®) Page(s): 41.

**Decision rationale:** The California MTUS recommends the use of cyclobenzaprine or Flexeril for short courses of treatment. As the patient has been on this medication for an extended period and has not demonstrated significant functional benefit, continuation would not be supported. As such, the prospective request for one (1) prescription of Flexeril 7.5mg #60 is not medically necessary or appropriate

**Unknown prescription of Theramine.: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

**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, Medical Food.

**Decision rationale:** The prospective request for an unknown prescription of Theramine is not medically necessary or appropriate. The requested medication includes choline. The ODG state "there is no known medical need for choline supplementation except for the case of long-term parenteral nutrition for individuals with choline deficiency secondary to liver deficiency." As the patient has no documentation of a history of liver deficiency, this type of medication would not be supported. As such, the prospective request for an unknown prescription of Theramine is not medically necessary or appropriate.

**Unknown prescription of Sentra PM.: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

**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.

**Decision rationale:** The prospective request for an unknown prescription of Sentra PM is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has continued pain complaints of the low back pain that interfere with activities of daily living. The requested medication is recommended for the treatment of insomnia with associated depression. The ODG recommend short-term use of medications in the treatment of insomnia. However, the clinical documentation on August 15, 2013 does not document any deficits in the patient's sleep patterns that would require medication management. As such, the prospective request for an unknown prescription of Sentra PM is not medically necessary or appropriate.

**One (1) pain management consultation with Dr. Arun Anand for cervical spine, shoulders and thoracic spine between 8/15/2013 and 10/20/2013.: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment, 4/27/2007, pg.56.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 163.

**Decision rationale:** The prospective request for one (1) pain management consultation with [REDACTED] for cervical spine, shoulders and thoracic spine between August 15, 2013 and October 20, 2013 is not medically necessary or appropriate. American College of Occupational and Environmental Medicine recommends consultation when a patient's diagnosis is complicated and additional advisory expertise is necessary. The clinical documentation submitted for review does not support that the patient's symptoms are not being