

Case Number:	CM13-0033652		
Date Assigned:	12/06/2013	Date of Injury:	06/30/2009
Decision Date:	04/14/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/10/2013

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 Physical Medicine & 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 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 63-year-old male who reported an injury on 06/30/2009. The mechanism of injury was not stated. The patient is currently diagnosed with persistent left ankle pain, status post delayed wound-healing in the left foot, internal derangement of the right knee, internal derangement of the left knee, low back pain, chronic left shoulder strain, insomnia, constipation, depression, and partial hearing loss. The patient was seen by [REDACTED] on 08/01/2013. Physical examination revealed improved lumbar range of motion with mild sensory deficit and an antalgic gait. Treatment recommendations included continuation of current medications including Acetedryl.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR COMPOUNDED ACETADRYLACETAMINOPHEN 500MG / DIPENHYDRAMINE 25MG, DISPENSED ON 7/01/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11-12. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The MTUS Guidelines indicate acetaminophen is recommended for treatment of chronic pain and acute exacerbations of chronic pain. The Official Disability Guidelines indicate that diphenhydramine is a sedating antihistamine often utilized as an over-the-counter medication for insomnia treatment. According to the documentation submitted, the employee does maintain a diagnosis of insomnia. However, the employee has continuously utilized this medication. There is no documentation of functional improvement despite ongoing use. There is also no indication of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product. Based on the clinical information received, the request is non-certified.