

Case Number:	CM13-0056330		
Date Assigned:	12/30/2013	Date of Injury:	10/31/2012
Decision Date:	05/06/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	11/22/2013

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 Illinois. 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 55-year-old female who reported an injury on 10/31/2012, after a fall that reportedly caused injury to her right shoulder, right upper extremity, right ankle, and right thigh. The injured worker's treatment history included surgical intervention for the knee, physical therapy, a knee brace, and multiple medications. The injured worker was evaluated on 08/28/2013. Physical findings included decreased range of motion of the cervical spine with tenderness to palpation of the right trapezius and paravertebral musculature, 4/5 motor strength of the right upper extremity, decreased right shoulder range of motion. Evaluation of the lumbar spine documented decreased range of motion secondary to pain with tenderness to palpation of the paravertebral musculature, and decreased motor strength of the left lower extremity. Evaluation of the left knee documented decreased range of motion with a positive patellofemoral compression sign. The injured worker's diagnoses included soft tissue injury to the right shoulder, left knee, and right foot status post arthroscopic surgery of the left knee, and sleep difficulties secondary to cervical spine pain. A treatment recommendation of postoperative physical therapy; medications to include Flurbiprofen and Cyclobenzaprine/Ketoprofen compounds, Ambien, and nonsteroidal anti-inflammatory drugs was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE PRESCRIPTION OF SENTRAZOLPIDEM PM -5 (DOS 8/28/13):
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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, Insomnia Treatments

Decision rationale: The retrospective request for Sentrazolpidem PM - 5, date of service 08/28/2013, is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address insomnia treatments. Official Disability Guidelines recommend pharmacological intervention with medications such as Sentrazolpidem that contain Sentra and zolpidem titrate for patients who have persistent insomnia complaints that have failed to respond to nonpharmacological measures. The clinical documentation submitted for review does indicate that the injured worker is diagnosed with insomnia due to chronic pain. However, there is no documentation that the injured worker has failed to respond to no pharmacologic treatments and requires pharmacological management. Additionally, the request as it is submitted does not provide a dosage, frequency, or duration of treatment. As this medication is only recommended for short durations of treatment, the appropriate of the request as it is submitted cannot be determined. As such, the retrospective request for a prescription Sentrazolpidem PM - 5, date of service 08/28/2013, is not medically necessary or appropriate.

RETROSPECTIVE PRESCRIPTION OF THERAPROXEN- 500 (DOS: 8/28/13): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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, Theramine And Medical Food.

Decision rationale: The retrospective request of theraproxen-500, date of service 08/28/2013, is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address the use of Theramine or medical food. The requested medication is a combination of medical food of Theramine and a nonsteroidal anti-inflammatory drug of naproxen. Official Disability Guidelines do not support the use of Theramine for pain management, as there is little scientific data to support the efficacy and safety of this medical food. Although nonsteroidal anti-inflammatory drugs are recommended for chronic pain control, the use of this combination would not be supported. California Medical Treatment Utilization Schedule does not support the use of any compounded medication that contains at least 1 drug or drug class that is not recommended. Additionally, the request as it is submitted does not provide a duration or frequency of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the retrospective prescription of Theraproxen-500 (date of service 08/28/2013) is not medically necessary or appropriate.