

<b>Case Number:</b>	CM13-0057993		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	08/17/2012
<b>Decision Date:</b>	04/04/2014	<b>UR Denial Date:</b>	11/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2013

### 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 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 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 35-year-old male who reported an injury on 08/17/2012, after 4 patio doors collapsed on him, which reportedly caused injury to the patient's left shoulder and low back. The patient's treatment history included medications and physical therapy. The patient was regularly monitored for aberrant behavior with urine drug screens. The patient's most recent clinical findings noted decreased lumbar range of motion secondary to pain with a positive straight leg raising test to the left and normal left-sided left shoulder range of motion. The patient's diagnoses included lumbar sprain/strain, lumbar disc protrusion, lumbar radiculopathy, left shoulder sprain/strain, and unspecified adjustment reaction. The patient's treatment plan included continuation of medications, shockwave therapy, an interferential unit for the lumbar spine, a psychological evaluation, and electrodiagnostic studies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**GABAdone, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested GABAdone #60 is not medically necessary or appropriate. The requested medication is a medical food combined with gabapentin. California Medical Treatment Utilization Schedule does recommend the use of gabapentin as a first-line medication in the management of a patient's neuropathic pain. However, Official Disability Guidelines do not support the use of medical food in the management of chronic pain. The clinical documentation submitted for review does not contain any exceptional factors to support extending treatment beyond guideline recommendations. Therefore, the use of GABAdone #60 is not medically necessary or appropriate.

**Sentra AM, #60:** Upheld

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

**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 Physician Reviewer's decision rationale: The requested Sentra AM #60 is not medically necessary or appropriate. The requested medication is considered a medical food that contains melatonin and tryptophan to assist the patient with insomnia, anxiety, and muscle relaxation. Official Disability Guidelines recommend pharmacological assistance for a patient's sleep hygiene or as an adequate assessment of sleep deficits that would respond to pharmacological intervention, and there is documentation that the patient has failed to respond to nonpharmacological interventions. The clinical documentation submitted for review does not provide an adequate assessment of the patient's sleep hygiene to support the need for pharmacological intervention. Additionally, there is no indication that the patient has not responded to nonpharmacological interventions. Therefore, the need for Sentra AM #60 is not medically necessary or appropriate.

**Sentra PM, #60:** Upheld

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

**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 Physician Reviewer's decision rationale: The requested Sentra PM #60 is not medically necessary or appropriate. The requested medication is considered a medical food that contains melatonin and tryptophan to assist the patient with insomnia, anxiety, and muscle relaxation. Official Disability Guidelines recommend pharmacological assistance for a patient's sleep hygiene or as an adequate assessment of sleep deficits that would respond to pharmacological intervention, and there is documentation that the patient has failed to respond to nonpharmacological interventions. The clinical documentation submitted for review does not

provide an adequate assessment of the patient's sleep hygiene to support the need for pharmacological intervention. Additionally, there is no indication that the patient has not responded to nonpharmacological interventions. Therefore, the need for Sentra PM #60 is not medically necessary or appropriate.

**Theramine, #90:** Upheld

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

**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®.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested Theramine #90 is not medically necessary or appropriate. Official Disability Guidelines do not recommend the use of Theramine in the management of a patient's chronic pain. There is not enough scientific data to support the efficacy and safety of this medication when used to treat chronic pain. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Therefore, the requested Theramine #90 is not medically necessary or appropriate.