

Case Number:	CM13-0062555		
Date Assigned:	12/30/2013	Date of Injury:	02/23/2013
Decision Date:	04/14/2014	UR Denial Date:	11/14/2013
Priority:	Standard	Application Received:	12/06/2013

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, has a subspecialty in Pediatric Rehabilitation Medicine 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 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 patient is a 41-year-old male who reported an injury on 02/23/2013 after he attempted to avoid a fall reportedly caused an acute onset of pain of the right upper extremity. The patient underwent surgical repair of the biceps tendon on 03/14/2013. This was followed by postoperative physical therapy and medication usage. The patient's most recent clinical evaluation documented that the patient had an acute flare-up of symptoms after lifting an object. Physical examination did not reveal a re-rupture, swelling, or ecchymosis. However, there was tenderness to palpation at the biceps tenodesis site. Treatment recommendations included ice, rest, and inflammatory medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE RANITIDINE 150 MG #30 X 1: 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 GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested ranitidine 150 mg #30 times 1 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for patients who are at risk for developing gastrointestinal symptoms related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support that the patient is at risk for developing gastrointestinal-related disturbances due to medication usage. Therefore, the need for ranitidine is not clearly established. As such, the requested ranitidine 150 mg #30 times 1 is not medically necessary or appropriate.

DENDRACIN TOPICAL 4 OZ 120 ML X 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Dendracin topical 4 ounces 120 ml times 1 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of non-steroidal anti-inflammatory drugs in a topical formulation when patients are intolerant of oral formulations of non-steroidal anti-inflammatory drugs or when oral formulations of non-steroidal anti-inflammatory drugs are contraindicated to the patient. The clinical documentation submitted for review does not provide any evidence that the patient cannot tolerate oral formulations of non-steroidal anti-inflammatory drugs or that oral formulations are contraindicated for this patient. Therefore, the need for a topical non-steroidal anti-inflammatory drug is not provided. As such, the requested Dendracin topical 4 ounce 120 mL times 1 is not medically necessary or appropriate.

SENTRA PM 405MG #60 X1: Upheld

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

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 and Insomnia Treatments.

Decision rationale: The requested Sentra PM 405 mg #60 times 1 is not medically necessary or appropriate. The requested medication is a medical food that is generally used as a sleep aid. The clinical documentation submitted for review does not provide an adequate assessment of the patient's sleep hygiene to support that pharmacological intervention is necessary. The clinical documentation does not include any evidence of sleep disturbances that have been non-responsive to non-pharmacological interventions. As such, the requested Sentra PM 405 mg #60 times 1 is not medically necessary or appropriate.

THERAMINE 450 MG #90 X2: Upheld

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

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 requested Theramine 450 mg #90 times 2 is not medically necessary or appropriate. The use of this medical food is not supported by Official Disability Guidelines. Official Disability Guidelines state there are no high-quality scientific studies that support the safety and efficacy of the use of Theramine. Therefore, the use of this medication is not supported by guideline recommendations. As such, the requested Theramine 450 mg #90 times 2 is not medically necessary or appropriate.