MAXIMUS Federal Services

Case Number:	CM14-0107698		
Date Assigned:	08/04/2014	Date of Injury:	11/05/2012
Decision Date:	09/22/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/11/2014

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 & Rehabilitation and is licensed to practice in California. 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 52-year-old male who reported an injury on 11/05/2012. The mechanism of injury was not provided for clinical review. The diagnoses include thoracic disc protrusion, thoracic disc degeneration, thoracic spondylosis, thoracic radiculopathy, lumbar spondylosis, lumbar spinal stenosis, lumbar radiculopathy, right knee meniscal tear, and right knee ACL tear. Previous treatments included medication and extracorporeal shockwave lithotripsy. Within the clinical note dated 12/05/2013, it was reported the injured worker complained of constant low back pain rated 4/10 in severity, and constant left hand pain/thumb pain rated 5/10 in severity. The injured worker complained of constant right knee pain rated 5/10 in severity. Upon the physical examination, the provider noted the left wrist range of motion was flexion at 50 degrees and extension at 50 degrees. The provider requested Somnicin, GABAdone, Sentra AM, Sentra PM, Theramine, and Xolido. However, a rationale was not provided for clinical review. The Request for Authorization was submitted and dated on 12/11/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Somicin Capsule #30 DOS: 4/3/13: 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, Medical Foods.

Decision rationale: The Official Disability Guidelines (ODG) note Somnicin is a medical food which is formulated to be consumed or administered internally under the supervision of a physician in which it is intended to for the specific dietary management of the disease or condition for which distinct nutritional requirements based on recognized scientific principals are established by medical evaluation. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request as submitted failed to provide the frequency of the medication. Therefore, the request for Somicin Capsule #30 DOS: 4/3/13 is not medically necessary and appropriate.

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: Pain (Updated 6/10/14) GABAdone.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Gabadone.

Decision rationale: The Official Disability Guidelines note GABAdone is intended to meet the nutritional requirements for inducing sleep, promoting restorative sleep and reducing snoring in patients who are experiencing anxiety related to sleep disorders. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request as submitted failed to provide the frequency of the medication. Therefore, the request for Gabadone #60 is not medically necessary and 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: Pain :(Updated 6/10/14) Medical Food.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) , Pain Sentra PM.

Decision rationale: The request for Sentra AM #60 is not medically necessary. The Official Disability Guidelines note Sentra is a medical food. Sentra is intended for the use of management of sleep disorders associated with depression. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request as submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

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: Pain :(Updated 6/10/14) Medical Food.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Sentra PM.

Decision rationale: The request for Sentra PM #60 is not medically necessary. The Official Disability Guidelines note Sentra is a medical food. Sentra is intended for the use of management of sleep disorders associated with depression. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request as submitted failed to provide the frequency of the medication. Therefore, the request for Sentra PM #60 is not medically necessary and 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: Pain :(Updated 6/10/14) Medical Food.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Theramine.

Decision rationale: The Official Disability Guidelines note Theramine is a medical food and it is not recommended. It is intended for the use of management of pain symptoms that include acute pain, chronic pain, fibromyalgia, neuropathic pain, and inflammatory pain. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request as submitted failed to provide the frequency of the medication. Therefore, the request for Theramine #90 is not medically necessary and appropriate.

Xolido 2% Cream: 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 Topical NSAIDs Page(s): 111-112.

Decision rationale: The California MTUS Guidelines note topical NSAIDs are recommended for the use of osteoarthritis and tendonitis, in particular that of the knee and/or elbow and other joints that are amiable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request as submitted failed to provide a treatment site. The request as submitted failed to provide the frequency and quantity of the medication. Therefore, the request for Xolido 2% Cream is not medically necessary and appropriate.