

Case Number:	CM14-0044952		
Date Assigned:	07/02/2014	Date of Injury:	01/04/2012
Decision Date:	08/25/2014	UR Denial Date:	03/18/2014
Priority:	Standard	Application Received:	04/13/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Oklahoma. 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 56-year-old female who reported an injury on 01/04/2012. The mechanism of injury was not stated. Current diagnoses include myofascial strain and sprain of the cervical spine, status post right shoulder surgery, myofascial sprain and strain of the thoracic spine, myofascial sprain and strain of the lumbar spine with radiculopathy, and paravertebral myofascitis. The injured worker was evaluated on 02/13/2014 with complaints of persistent pain in the cervical spine with radiation into the upper extremities, as well as pain in the lumbar spine with radiation into the lower extremities. Previous conservative treatment includes physical therapy and medication management. The current medication regimen includes, Ibuprofen, Theramine, Trepadone and Sentra PM. Physical examination revealed hypertonicity and tenderness to palpation over the cervical spine, slightly limited cervical range of motion, positive shoulder depression testing, tenderness to palpation over the lumbar spine, limited lumbar range of motion, positive Kemp's testing and positive straight leg raising. Treatment recommendations at that time included, authorization for acupuncture for the cervical and lumbar spine, and continuation of the current medication regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture; eight (8) visits 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated, and maybe used as an adjunct to physical rehabilitation and/or surgical intervention. The time to produce functional improvement includes 3 to 6 treatments. The current request for 8 sessions of acupuncture exceeds guideline recommendations. There is also no specific body part listed in the current request. As such, 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 Chapter, 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) Chronic Pain Chapter, Sentra PM.

Decision rationale: Official Disability Guidelines state Sentra PM is a medical food intended for use in management of sleep disorders associated with depression. The injured worker does not maintain a diagnosis of insomnia or depression. Additionally, there is no frequency listed in the current request. Therefore, the medical necessity for the requested medication has not been established. As such, the request is not medically necessary.

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 Chapter, 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) Chronic Pain Chapter, Theramine.

Decision rationale: Official Disability Guidelines state Theramine is not recommended. It is intended for use in the management of pain syndromes. The injured worker has continuously utilized this medication for an unknown duration without any evidence of objective functional improvement. Guidelines do not recommend the use of Theramine. There is also no specific frequency listed in the current request. As such, the request is not medically necessary.

Trepadone # 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 Chapter, 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) Chronic Pain Chapter, Medical Food.

Decision rationale: Official Disability Guidelines state medical food is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are established by medical evaluation. The medical necessity for the requested medication has not been established, as there is no evidence of a nutritional deficit. There is also no frequency listed in the current request. As such, the request is not medically necessary.

Capsaicin 0.025%, Flurbiprofen 20%, Tramadol 15%, Menthol 2%, Camphor 2% topical cream # 240 gms: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is Diclofenac. Capsaicin in a 0.025% formulation is recommended for treatment of osteoarthritis. As per the documentation submitted, the injured worker does not maintain a diagnosis of osteoarthritis. There is also no frequency listed in the current request. Based on the clinical information received in the above mentioned guidelines, the request is not medically necessary.