

<b>Case Number:</b>	CM14-0048546		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	03/04/2009
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	03/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/28/2014

### 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 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 58-year-old male who reported an injury on 03/04/2009. The mechanism of injury was not provided. On 06/19/2014, the injured worker presented with upper extremity complaints and constant pain in the right arm that travels up the shoulder near the elbow. The diagnoses were right elbow pain and right elbow ulnar compression. Prior therapy included epidural steroid injection, medications, and the use of topical cream. A current medication list was not provided. The provider recommended retrospective Theramine, GABAdone, and Percocet. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Theramine Quantity: 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 Theramine

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain, Medical Food.

**Decision rationale:** The request for Retro Theramine Quantity: 60 is not medically necessary. The Official Disability Guidelines state medical food is recommended when it is formulated to

be consumed or administered enterally under the supervision of a physician and is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are required. The product must be a food for oral or tube feeding. There is a lack of documentation that the injured worker is recommended for a specific dietary management for a disease or condition of which nutritional requirements are required. Additionally, the product must be for oral or tube feeding. The provider's rationale for the request was not provided. Additionally, the frequency and quantity of the medication was not provided in the request as submitted. As such, medical necessity has not been established.

**Retro Gabadone Quantity: 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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain, Medical Food.

**Decision rationale:** The request for Retro Gabadone Quantity: 60 is not medically necessary. The Official Disability Guidelines state medical food is recommended when it is formulated to be consumed or administered enterally under the supervision of a physician and is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are required. The product must be a food for oral or tube feeding. There is a lack of documentation that the injured worker is recommended for a specific dietary management for a disease or condition of which nutritional requirements are required. Additionally, the product must be for oral or tube feeding. The provider's rationale for the request was not provided. Additionally, the frequency and quantity of the medication was not provided in the request as submitted. As such, medical necessity has not been established.

**Retro Percocet Quantity: 120 10/325mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

**Decision rationale:** The request for Retro Percocet Quantity: 120 10/325 mg is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the management of chronic pain. The Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse behavior, and side effects. Additionally, the provider does not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.