

Case Number:	CM14-0095262		
Date Assigned:	07/25/2014	Date of Injury:	10/11/1989
Decision Date:	09/09/2014	UR Denial Date:	06/18/2014
Priority:	Standard	Application Received:	06/23/2014

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 and is licensed to practice in California and Washington. 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 55-year-old male who reported an injury on 10/11/1989. The injured worker suffered a low back injury when he was struck by a fallen beam. The current diagnosis is lumbar radiculopathy. The injured worker was evaluated on 07/17/2014 with complaints of 7/10 pain. It is noted that the injured worker has undergone multiple lumbar spine surgeries. The most recent surgery was an L2-S1 fusion on 07/30/2013. Physical examination revealed a limping gait, bilateral tenderness and spasm at L3 through L5, decreased lumbar range of motion, decreased sensation along the left lower extremity, decreased sensation to pinprick along the right lateral leg, and diminished deep tendon reflexes in the bilateral lower extremities. It is noted that the injured worker underwent an magnetic resonance imaging (MRI) of the lumbar spine and cervical spine on 10/31/2011. The current medication regimen includes MS Contin ER 30 mg, Norco, Ambien 10 mg, and Soma. Treatment recommendations at that time included prescriptions for Theramine, Sentra PM, and Sentra AM. The injured worker was also prescribed a ketoprofen cream. It is noted that a previous request for authorization was submitted on 06/03/2014 for the medications Sentra AM, Sentra PM, and Theramine.

IMR ISSUES, DECISIONS AND RATIONALES

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

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 Guideline(ODG) Treatment Workers Compensation (TWC).

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: The Official Disability Guidelines state a 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. It is noted that the injured worker was issued a prescription for Sentra AM to help with alertness and energy. However, there is no documentation of chronic fatigue or lethargy. A request for authorization was also submitted in 06/2014 for Sentra AM. There is no documentation of objective functional improvement despite the ongoing use of this medication. There is also no frequency listed in the request. As such, the request is not medically necessary and 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) Pain Treatment Workers Compensation (TWC).

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: The Official Disability Guidelines state Sentra PM is a medical food intended for use in the management of sleep disorders associated with depression. The injured worker does not maintain a diagnosis of insomnia or depression. The injured worker is also currently utilizing Ambien 10 mg. The medical necessity for the requested medication has not been established. There is also no frequency listed in the request. As such, the request 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 (ODG) Pain Treatment Workers Compensation (TWC).

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: The Official Disability Guidelines do not recommend Theramine. Therefore, the current request cannot be determined as medically appropriate. There is also no frequency listed in the request. As such, the request is not medically necessary and appropriate.

Ketoprofen creme 10% #20: 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 111-113 Page(s): 111-113.

Decision rationale: The California Medical Treatment Utilization Schedule (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 non-steroidal anti-inflammatory drugs (NSAIDs) is Diclofenac. Therefore, the current request is not medically appropriate. There is also no frequency listed in the request. As such, the request is not medically necessary and appropriate.

Sprix 1 Nasal Spray #5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page 67-72 Page(s): 67-72.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Guidelines state non-steroidal anti-inflammatory drugs (NSAIDs) are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. As per the documentation submitted, the injured worker was issued a prescription for Sprix nasal spray in 05/2014. There is no documentation of objective functional improvement despite the ongoing use of this medication. There was also no mention of a contraindication to oral NSAIDs. There is no frequency listed in the request. Based on the clinical information received, the request is not medically necessary and appropriate.