

Case Number:	CM14-0188807		
Date Assigned:	11/19/2014	Date of Injury:	06/03/2013
Decision Date:	01/07/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/12/2014

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 Orthopedic Surgery 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 44 year old, who was injured on June 3, 2013, while performing regular work duties. The mechanism of injury is from catching falling boxes, and resulting in injury to the right shoulder and right upper extremity. The Utilization Review indicates a magnetic resonance imaging of the right shoulder showed a rotator cuff tear, however this report was not provided for this review. On August 6, 2014, a formal pain evaluation was obtained. On September 18, 2014, the injured worker underwent extracorporeal shockwave therapy. The efficacy or function improvement of the shockwave therapy is not provided for this review. Additional therapies/treatments received by the injured worker include: infrared, electro-analgesic, vasopneumatic devices, myofascial release. The efficacy and functional improvement of these therapies/treatments is not provided for this review. The need for and intended use of Theramine are not indicated within the provided records. The request for authorization is for Theramine, #60, Medical Foods. The primary diagnosis is unspecified enthesopathy. Associated diagnoses are right shoulder impingement syndrome, right elbow later epicondylitis, and right wrist pain. On October 27, 2014, Utilization Review non-certified the request for Theramine, #60, Medical Foods, per the ODG guidelines, citing that medical foods are not recommended for treatment of chronic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Theramine # 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter

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 CA MTUS/ACOEM is silent on the issue of Theramine. According to the ODG Pain Chapter, regarding Theramine states that it is not recommended, as there is a lack of high quality studies supporting usage. Therefore the request is considered not medically necessary.