

Case Number:	CM14-0209559		
Date Assigned:	12/22/2014	Date of Injury:	02/25/2010
Decision Date:	02/18/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabn

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 patient is a 62-year-old female with a date of injury of 02/25/2010. The medical file provided for review includes a QME report dated 06/23/2014 and 11/21/2014, and 2 urine drug screens. According to AME report dated 06/23/2014, the patient presents with bilateral elbow, wrist/hand, and knee pain. The patient is status post right knee ACL reconstruction with arthroscopy and extensive 3 compartments synovectomy on 05/10/2010. The patient complains of right upper extremity pain which she rates as 9/10 on a pain scale. In respect to her left upper extremity, the patient complains of intermittent discomfort which extends into the left elbow and rates the pain as 8/10. In respect to the bilateral knee, the patient reports constant discomfort which she rates as 9-10/10 on a pain scale and states that pain increases with weight bearing. There was intermittent popping and cracking sensations noted. The listed diagnoses are bilateral elbow, bilateral wrist, bilateral hand, and bilateral knee contusion/strain. Physical examination of the upper extremity demonstrated intact motor reflex testing and decreased sensory testing. There was decreased range of motion of the bilateral wrist. Examination of the lower extremity revealed decreased motor testing and intact sensory and reflex testing. There is decreased range of motion of the bilateral knee and tenderness noted. Anticipated future medical treatments include oral antiinflammatory and non-narcotic analgesic medication, as well as orthopedic followup on intermittent basis. The utilization review discusses a progress report dated 10/23/2014 which was not provided for my review. According to this report, the patient presents with significant systolic hypertension and pain in her muscles. She also complains of pain in the shoulders and bilateral knee. Patient says she still has constipation and upset stomach and

sleeping issues. It was noted the patient is currently working full time. Current medication regimen includes Norvasc, atenolol, omeprazole, tramadol ER, Hyzaar, nizatidine, and Theramine medical food. The utilization review denied the request on 11/20/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

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 chapter, Theramine

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

Decision rationale: This patient presents with chronic upper and lower extremity complaints. The current request is for Theramine #90. The ACOEM and MTUS guidelines do not discuss Theramine. The ODG guidelines under pain chapter has the following regarding Theramine, "Not recommended for the treatment of chronic pain. Theramine is a medical food from ██████████, ██████████, that is a proprietary blend of gamma-aminobutyric acid [GABA] and choline bitartrate, L-arginine, and L-serine. It is intended for use in the management of pain syndromes that include acute pain, chronic pain, fibromyalgia, neuropathic pain, and inflammatory pain." Theramine is not supported by ODG. This request IS NOT medically necessary.

Tramadol ER 150mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids; Medication for Chronic Pain Page(s): 88-89, 76-78; 60-61.

Decision rationale: This patient presents with chronic upper and lower extremity complaints. The current request is for tramadol ER 150 mg #60. For chronic opioid use, the MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, activities of daily livings (ADLs), adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The medical file provided for review includes 2 AME reports dated 06/23/2014 and 11/21/2014, and 2 urine drug tests from 04/01/2014 and 06/05/2014. According to urine drug screen dated 04/01/2014, the patient's current medication regimen includes tramadol. It appears the patient has been taking tramadol as

early as 04/01/2014. In this case, progress reports provide a current pain level and notes that the patient is working full time. However, recommendation for further use cannot be supported as there is no documentation of before and after pain scale to denote decrease in pain. In addition, there are no other specific functional improvements or changes in ADL discussed. AME report dated 06/23/2014 documents that the patient's future treatment should include "anti-inflammatory and non-narcotic analgesic medications." Therefore, this request is not medically necessary.