MAXIMUS Federal Services

Case Number:	CM15-0018707		
Date Assigned:	02/06/2015	Date of Injury:	08/24/2010
Decision Date:	04/03/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/02/2015

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, Arizona
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 32-year-old female who reported injury on 08/24/2010. The mechanism of injury was not provided. The injured worker's diagnoses included thoracic or lumbosacral neuritis or radiculitis unspecified. Other therapies included aquatic therapy. The injured worker underwent a knee surgery. The documentation of 11/04/2014 revealed the injured worker had subjective complaints of constant low back pain radiating to the right lower extremity with numbness and tingling. The pain with medications was noted to be an 8/10. The documentation indicated the topical creams and patches helped decrease pain and help the injured worker walk longer, increase sleep, and decrease oral medications. The injured worker's current pain was noted to be a 6/10 to the lower extremity and 3/10 on the right knee. The physical examination findings revealed the injured worker had decreased range of motion and a straight leg raise and femoral stretch test that were positive on the right. There was tenderness along the lumbar spine with spasms. The injured worker had an antalgic gait and patellar grinding. The treatment plan included tramadol 160 mg, cyclobenzaprine hydrochloride 7.5 mg #60, Terocin patches, Menthoderm gel, Calypxo cream, Norco 10/325 mg, a combination Toradol and B12 injection, psychological evaluation for anxiety, physical therapy, and aquatic therapy. Additionally, a request was made for a TENS unit. There was no specific request for the medical foods that were requested and there was no specific rationale.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabadone #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Gabadone.

Decision rationale: The Official Disability Guidelines indicate that Gabadone is not recommended. There was no documented rationale or exceptional factors noted to support the use of the medication. The request as submitted failed to indicate the frequency for the Gabadone. Given the above, the request for Gabadone #60 is not medically necessary.

Sentra PM #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Sentra PMï¿½.

Decision rationale: The Official Disability Guidelines do not recommend Sentra PM. The documentation submitted for review failed to indicate the injured worker had difficulty sleeping and there was a lack of documented rationale for the request for the medical food Sentra PM. The request as submitted failed to indicate the frequency for the Sentra PM. Given the above, the request for Sentra PM #60 is not medically necessary.

Trapadone #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Trepadoneï¿½.

Decision rationale: The Official Disability Guidelines indicate that Trepadone is not recommended. There is a lack of documentation of a rationale for the use of Trepadone. The request as submitted failed to indicate the frequency for the requested medical food. Given the above, the request for Trepadone #90 is not medically necessary.

Genicin Capsules #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine Sulfate Page(s): 50.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend glucosamine sulfate for patients with moderate arthritis pain, especially knee osteoarthritis, and that only 1 medication should be given at a time. The clinical documentation submitted for review failed to indicate the injured worker had osteoarthritis. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication.