MAXIMUS Federal Services

| Case Number: | CM15-0136924 | | |
|---|---|---|---|
| Date Assigned: | 07/24/2015 | Date of Injury: | 06/18/2014 |
| Decision Date: | 08/24/2015 | UR Denial Date: | 06/19/2015 |
| Priority: | Standard | Application Received: | 07/15/2015 |

## 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: North Carolina
Certification(s)/Specialty: Family Practice

## 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 36-year-old female, who sustained an industrial injury on 6/18/14. She reported injury to her back related to a motor vehicle accident. The injured worker was diagnosed as having lumbar radiculopathy. Treatment to date has included a lumbar MRI on 4/21/15 showing a 4mm protrusion at L5-S1, a pulmonary stress test, chiropractic treatments and acupuncture. As of the PR2 dated 3/12/15, the injured worker reports lower back pain that radiates to the legs. She rates her pain a 7/10 and has difficulty sleeping due to the pain. Objective findings include decreased lumbar range of motion. The treating physician prescribed Tylenol #3, Terocin, Flurbi cream, Genicin, Somnicin, Gabacyclotram cream and laxacin. On 6/19/15, the injured worker rated her pain a 5/10 in the lower back that radiated to the right leg. The treating physician noted a negative straight leg raise test and decreased lumbar range of motion. The treating physician requested Theramine #180.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Theramine 180 tablets:** 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 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) medical foods.

**Decision rationale:** The California chronic pain medical treatment guidelines and the ACOEM do not specifically address the requested medication. The ODG states that medical foods are not considered medically necessary except in those cases in which the patient has a medical disorder, disease or condition for which there are distinctive nutritional requirements. The requested medication is for weight loss. The criteria per the ODG have not been met and therefore the request is not medically necessary.