

Case Number:	CM13-0016347		
Date Assigned:	11/06/2013	Date of Injury:	11/01/2012
Decision Date:	01/30/2014	UR Denial Date:	08/08/2013
Priority:	Standard	Application Received:	08/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management, 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 physician 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 patient is a 49-year-old injured worker who reported an injury on 11/01/2012. The mechanism of injury was noted to be repetitive work. Symptoms were noted as pain that radiates from neck to left shoulder and arm, and pain in lower back traveling to left leg. Physical exam findings included tenderness to palpation in the bilateral thoracolumbar spinal musculature and sacroiliac joints, decreased range of motion in the lumbar spine, positive bilateral straight leg raise testing, normal sensation and motor strength to the lower extremities, and low back pain with range of motion of the left hip. The diagnoses are listed as lumbar sprain, lumbar degenerative disc disease, left lumbar radiculopathy, and lumbar scoliosis. It was noted that the patient was being treated conservatively with NSAIDs, muscle relaxants, sparing use of narcotics, physical therapy, and a home exercise program. A recommendation was made for a lumbar epidural injection at L4-5. It was noted that the patient had an MRI on 01/24/2013, which demonstrated mild disc desiccation and mild bilateral facet arthropathy at L4-5, and a 3 mm broad-based disc bulge causing no significant foraminal stenosis. The patient had EMG and NCV studies on 02/08/2013, which revealed normal results with no evidence of peripheral neuropathy or significant lumbar radiculopathy of the left lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection at the L4-L5 2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state that the criteria for the use of epidural steroid injections include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and the patient needs to be initially unresponsive to conservative measures, including exercise, physical methods, NSAIDs, and muscle relaxants. The patient was noted to complain of radiculopathy; however, the most recent physical exam findings showed normal reflexes, motor strength, and sensation to the lower extremities. Additionally, it was noted that the MRI showed a disc bulge at L4-5; however, there was no noted significant foraminal stenosis. Furthermore, electrodiagnostic studies were negative for findings of radiculopathy. Despite the patient's reported symptoms of radiculopathy in the left lower extremity, objective findings, imaging studies, and electrodiagnostic testing did not confirm radiculopathy. The request for lumbar epidural steroid injection at the L4-L5 2, is not medically necessary and appropriate.

Three month supply of Ultracet one tablet every 4-6 hours as needed for pain: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state that, for patients taking opioid medications, ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects is required. The pain assessment should include current pain, the least reported pain over the period since the last assessment, average pain and intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Additionally, specific documentation regarding the 4 A's for ongoing monitoring is required. The 4 A's are noted to include analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The medical records submitted for review failed to include detailed documentation regarding the patient's medication use, as well as a detailed pain assessment and documentation of the 4 A's for ongoing monitoring of patients taking opioid medications. The request for a three month supply of Ultracet one tablet every 4-6 hours as needed for pain control is not medically necessary and appropriate.

Sinralyne-PM one capsule at bedtime to help with sleep: 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).

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

Decision rationale: The Official Disability Guidelines state that Sentra PM is a medical food intended for the use in management of sleep disorders associated with depression, and is a proprietary blend of choline bitartrate, glutamine, and 5-hydroxytryptophan. The guidelines further specify that there is no known medical need for choline supplementation except for the case of long term parenteral nutrition or for individuals with choline deficiency secondary to liver deficiency. Glutamic acid is used for the treatment of hypochlorhydria and achlorhydria. Treatment indications include those for impaired intestinal permeability, short bowel syndrome, cancer, and critical illnesses. For 5-hydroxytryptophan, this supplement has been found to be possibly effective in the treatment of anxiety disorders, fibromyalgia, obesity, and sleep disorders. The medical records submitted for review failed to show detailed documentation regarding the patient's use of Sentra PM. Additionally; the patient does not have indications as stated by the guidelines for the use of choline, glutamic acid, or 5-hydroxytryptophan. The request for Sintralene-PM one capsule at bedtime to help with sleep is not medically necessary and appropriate.