

Case Number:	CM14-0051043		
Date Assigned:	07/07/2014	Date of Injury:	04/28/2010
Decision Date:	08/27/2014	UR Denial Date:	03/19/2014
Priority:	Standard	Application Received:	04/18/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

This is a 34-year-old male with a 4/28/10 date of injury. The injury occurred in the course of his usual work duties. According to a 2/26/14 progress note, the patient complained of neck pain that radiated down bilateral upper extremity, low back pain that radiated down the bilateral lower extremities, upper extremity pain in the right hand and shoulder, and lower extremity pain in the right hip and knee. He stated that his pain is unchanged since his last visit. He rated his pain as 6/10 in intensity with medications and 9/10 in intensity without medications. Objective findings: spasm noted bilaterally in the paraspinal muscles; tenderness noted in the bilateral paravertebral C5-7 area upon palpation; pain significantly increased with flexion, extension, and rotation; left foot MCP region 2-4 digit web space primarily fungal type infection with 1 cm opening. Diagnostic impression: chronic pain, cervical radiculitis, cervical spinal stenosis, lumbar radiculitis, myositis/myalgia, insomnia, left foot infection. Treatment to date includes medication management, activity modification, and epidural steroid injections. A UR decision dated 3/19/14 denied the requests for Restone and Tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Restone 3-100mg at bedtime as needed #60, prescribed 2-26-14: 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.

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 Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/cdi/restone.html>.

Decision rationale: Restone is a combination of melatonin and l-tryptophan used to help sleep problems, jet lag, anxiety or depression, and boosting the immune system. However, the FDA states that specific requirements for the safety or appropriate use of medical foods have not yet been established. In addition, there is no rationale or indication provided for the treatment with the requested medications. It is documented that the patient has severe clinical insomnia. However, there is no discussion provided of non-pharmacologic alternatives, such as proper sleep hygiene, for the patient's sleep disorder. In addition, in order for a medicinal food, l-tryptophan, to be supported by guidelines, the product must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements. There is no documentation provided that the patient is deficient in l-tryptophan. Therefore, the request is not medically necessary.

TRAMADOL 50MG EVERY 8 HOURS AS NEEDED #90, PRESCRIBED 2-26-14:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS: Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 9792.24.2 Page(s): 78-81.

Decision rationale: The MTUS Chronic Pain Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. In fact, in the progress reports reviewed between 10/9/13 and 2/26/14, the patient stated that his pain is unchanged or has worsened. In addition, a urine drug screen dated 9/11/13 was inconsistent for Tramadol. There is no documentation that the provider has addressed this issue. Furthermore, there is no documentation of lack of aberrant behavior or adverse side effects. Therefore, the request is not medically necessary.