

Case Number:	CM13-0012203		
Date Assigned:	12/18/2013	Date of Injury:	02/04/2005
Decision Date:	02/25/2014	UR Denial Date:	08/05/2013
Priority:	Standard	Application Received:	08/16/2013

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 Occupational Medicine, 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:

Claimant is a 57 year old male with date of injury 2/4/2005. Per progress note dated 7/16/2013, the claimant is being treated for left shoulder pain with radiation to the cervical spine as well as lumbar spine pain rated 8/10 with radiation down the legs to the feet. On exam there is reduced lumbar spine range of motion. Diagnoses include 1) lumbar spine sprain/strain 2) lumbar spine radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 1 Magnetic Resonance Imaging (MRI): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: Progress note dated 7/16/2013 does not provide any clinical evidence of alterations in sensation, positive nerve root signs, lower extremity weakness or alterations in reflexes. The progress note dated 4/16/2013 did include a positive Kemp's test, but there remains a lack of current clinical evidences to support the diagnosis of radiculopathy, to suggest the presence of nerve root impingement, or to indicate the patient is experiencing progressive

neurologic compromise. Clinical notes reviewed back to 8/2012 did not show any significant evidence of radiculopathy. The claimant did complain of sciatica type pain, with no clinical evidence. Per ACOEM Guidelines: "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)." Since there is no clear evidence of nerve root compromise on exam, MRI is not supported by these guidelines. The request for MRI of lumbar spine is determined to not be medically necessary.

Prospective request for 1 prescription of Tramadol 50mg #90 with 1 refill: Overturned

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.

Decision rationale: The claimant has been taking Tramadol 50 mg three times daily since at least June 2012. Per Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§9792.20 - 9792.26 MTUS (Effective July 18, 2009), opioids for chronic pain recommendations include the following: -Neuropathic pain: Opioids have been suggested for neuropathic pain that has not responded to first-line recommendations (antidepressants, anticonvulsants). There are no trials of long-term use. There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant neuropathy. See Opioids for neuropathic pain. - Chronic back pain: Appears to be efficacious but limited for short-term pain relief, and longterm efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a timelimited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. (Martell-Annals, 2007) (Chou, 2007) There are three studies comparing Tramadol to placebo that have reported pain relief, but this increase did not necessarily improve function. (Deshpande, 2007). Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (â‰¤70 days). This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, longrange adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment

effect. (Ballantyne, 2006) (Furlan, 2006) Long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate (56% in a 2004 meta-analysis). (Kalso, 2004) There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. (Martell-Annals, 2007) Current studies suggest that the "upper limit of normal" for opioids prior to evaluation with a pain specialist for the need for possible continuation of treatment, escalation of dose, or possible weaning, is in a range from 120-180 mg morphine equivalents a day. (Ballantyne, 2006) (AMDG, 2007) There are several proposed gui

Prospective request for 1 prescription of Omeprazole 20mg #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

Decision rationale: The clinical documents available for review do not provide any evidence of gastritis or that the claimant is at intermediate or high risk for gastrointestinal events. The request for Omeprazole 20 mg #30 with 1 refill is determined to not be medically necessary.

Prospective request for nerve conduction velocity (NCV) of the right lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Official Disability Guidelines, Low Back- Lumbar and Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: Nerve conduction velocity and electromyography are neurophysiologic tests that are useful in identifying neuropathy involving specific nerve tracts. Per ACOEM Guidelines, "electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." Review of the clinical documents provided do not provide sufficient evidence of neurologic dysfunction, such as alteration in reflexes, alteration in sensation, muscle weakness, or positive nerve root signs in a dermatomal pattern to suggest nerve root compromise. It is determined that the request for nerve conduction velocity (NCV) of the right lower extremity is not medically necessary.

Prospective request for Electromyography (EMG) of the right lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Low Back- Lumbar and Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: Nerve conduction velocity and electromyography are neurophysiologic tests that are useful in identifying neuropathy involving specific nerve tracts. Per ACOEM Guidelines, "electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." Review of the clinical documents provided do not provide sufficient evidence of neurologic dysfunction, such as alteration in reflexes, alteration in sensation, muscle weakness, or positive nerve root signs in a dermatomal pattern to suggest nerve root compromise.

Prospective request for 12 physical therapy (PT) sessions: 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 Physical Medicine Page(s): 98-99.

Decision rationale: The claimant's date of injury was 9 years ago. The claims administrator requested additional information from the requesting provider that would have been useful in making a decision on this request that was not provided, and is not included in the documents provided for this review. It is highly likely that the claimant has had physical therapy within the past 9 years, since the claimant was injured. There is no documentation available that describes the number of physical therapy sessions to date, no assessment of the claimants response to physical therapy, and no explanation of why physical therapy is necessary at this time. The request for physical therapy 12 sessions is determined to not be medically necessary.