

Case Number:	CM13-0066659		
Date Assigned:	01/03/2014	Date of Injury:	08/13/2007
Decision Date:	05/19/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/16/2013

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 Physical Medicine and Rehabilitation, and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 34-year-old male who reported a work-related injury on 08/13/2007. The mechanism of injury was noted as the patient was walking along the side of a forklift driver to deliver ice boxes and ensure that the ice box would not tip or fall over and that it arrived to the correct location and the injured worker stated he did not recall how the injury occurred and remembered waking up in the hospital. The injured worker stated he believed that the ice box fell on top of him and crushed him. The injured worker had a full body MRI done and was treated with medication and was told that he had multiple head fractures and a back injury. The injured worker was released to go home after a week and was sent home with medications. The injured worker has undergone physical therapy and imaging studies. A request was made for Tramadol, Cyclobenzaprine, Ondansetron, pain management consultation, NCS of bilateral upper extremities, 2 cervical and lumbar epidural injections, NCS of bilateral lower extremities, and EMG of bilateral upper and lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF TRAMADOL ER 150MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Opioids, On-going use Page(s): 78-80. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TRAMADOL, OPIOIDS, ON-GOING USE, , 78-80

Decision rationale: Recent clinical documentation stated that the injured worker presented for follow-up and had a recurrence of his symptoms after having a "pop" in his back with severe pain 3 weeks prior. The injured worker had continued lower back pain and stated he had numbness and tingling to both legs and hands. He had also been depressed secondary to his pain. The injured worker was prescribed Tramadol ER 150 mg every day for chronic pain relief. California Medical Treatment Guidelines for chronic pain state that Tramadol is a centrally acting synthetic opioid analgesic and is not recommended as a first line oral analgesic. There was no documentation submitted stating the injured worker had tried and failed first line therapy for his pain relief before beginning Tramadol. In addition, guidelines state there should be an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects for patients taking opioids for pain relief. There was no evidence of a pain assessment noted for the injured worker in which he noted his pain before and after taking medications. Guidelines further state to continue opioids if the patient has returned to work and if the patient has improved functioning and pain relief. There was no evidence given that the injured worker had returned to work and no documentation of the injured worker's improved functioning and pain relief due to the use of Tramadol. Therefore, the use of Tramadol would not be supported for the injured worker. The decision for 1 prescription of Tramadol ER 150 mg is not medically necessary and appropriate.

CYCLOBENZAPRINE 7.5MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Page(s): 41-42.

Decision rationale: California Medical Treatment Guidelines state that Cyclobenzaprine is recommended as an option using a short course of therapy. Guidelines state that treatment should be brief and the addition of Cyclobenzaprine to other agents is not recommended. Cyclobenzaprine is not recommended for chronic use. In addition, there were no improvements noted for the patient due to the use of Cyclobenzaprine. Given the above, the decision for Cyclobenzaprine 7.5 mg is not medically necessary and appropriate.

1 PRESCRIPTION OF ONDANSETRON 4MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Editorial Board Palliative Care: Practice Guidelines. Nausea and vomiting. Utrecht, The Netherlands: Association of Comprehensive Cancer Centres (ACCC); 2006 Jan 12. 28 p.

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, Ondansetron (Zofran), Antiemetics.

Decision rationale: Per submitted clinical documentation, Ondansetron 4 mg daily was recommended for the injured worker to counter effect nausea from NSAIDs prophylaxis. Official Disability Guidelines state that antiemetics are recommended for acute use and Ondansetron is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for postoperative use and for gastroenteritis. There was no documentation stating the injured worker had symptoms of gastroenteritis which would warrant the use of Ondansetron for the injured worker. In addition, there were no reported significant improvements due to the use of Ondansetron. Therefore, the decision for 1 prescription of Ondansetron 4 mg is not medically necessary and appropriate.

1 PAIN MANAGEMENT CONSULTATION FOR EPIDURAL INJECTIONS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment, 4/27/2007, pg. 56.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

Decision rationale: California Medical Treatment Guidelines state that upon ruling out a potentially serious condition, conservative management is provided and if the complaint persists, then the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. There was no rationale provided for the request for a pain management consultation for the injured worker. Per recent clinical documentation, the injured worker was noted to have a flare up in his pain and until that event, it was noted that the injured worker's current conservative care had been controlling his pain symptoms. There was no evidence given in the submitted clinical documentation that the injured worker's medications and prior conservative care would not be able to relieve his pain symptoms. Therefore, the request for 1 pain management consultation for epidural injections is not medically necessary.

1 NCS OF THE BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: Per clinical documentation submitted, it was reported the injured worker had nerve conduction studies done. These prior nerve conduction studies were not submitted for review. Guidelines state that electromyography and nerve conduction velocities may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both,

lasting more than 3 or 4 weeks. There was no evidence given the injured worker had recently tried and failed conservative treatment to include physical therapy or home exercise prior to ordering electrodiagnostic studies. There was also no rationale provided for the request for electrodiagnostic studies for the injured worker. Therefore, the decision for 1 NCS of the bilateral upper extremities is not medically necessary and appropriate.

2 CERVICAL AND LUMBAR EPIDURAL INJECTIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009) Epidural steroid injections (ESIs),.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs), Page(s): 46.

Decision rationale: California Medical Treatment Guidelines state criteria for the use of epidural steroid injections includes radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. It was reported the injured worker had undergone imaging studies and electrodiagnostic testing; however, the official imaging and electrodiagnostic studies were not submitted for review. Therefore, the radiculopathy findings for the injured worker are not able to be corroborated by imaging studies or electrodiagnostic testing per criteria for the use of epidural steroid injections. In addition, the levels were not specified for the injured worker's cervical and lumbar epidural injections per the request. Therefore, the decision for 2 cervical and lumbar epidural injections is not medically necessary and appropriate.

1 NCS OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Nerve conduction studies (NCS)

Decision rationale: California Medical Treatment Guidelines state that electrodiagnostic studies may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. Per submitted clinical documentation, the injured worker reported undergoing electrodiagnostic testing; however, this prior testing was not submitted for review. There was no rationale provided for repeat electrodiagnostic testing for the injured worker as Official Disability Guidelines state that nerve conduction studies are not recommended for low back symptoms. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Therefore, the decision for 1 NCS of the bilateral lower extremities is not medically necessary and appropriate.

1 (EMG) Electromyography of the bilateral upper extremities: 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 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: Per recent clinical documentation, the injured worker was noted to have numbness and tingling to both legs and hands. Guidelines state that electromyography and nerve conduction velocities may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. Per physical exam of the injured worker, he was noted to have normal motor strength, reflexes, and sensations in bilateral upper extremities. There were no objective findings of subtle focal neurologic dysfunction noted in the injured worker per physical exam. Therefore, the decision for 1 EMG of the bilateral upper extremities is not medically necessary and appropriate.

1 (EMG) Electromyography of the bilateral lower extremities: 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): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Electrodiagnostic studies (EDS).

Decision rationale: California Medical Treatment Guidelines state that electromyography may be helpful to identify subtle focal neurologic dysfunction in patients with neck or arm symptoms lasting more than 3 or 4 weeks. There were no objective findings of neurologic dysfunction in the injured worker with the exception of diminished sensation to L5 nerve root. Official Disability Guidelines state that EMGs are recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy after 1 month of conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Therefore, there was no rationale provided for the request for EMG of the bilateral lower extremities. As such, the decision for 1 EMG of the bilateral lower extremities is not medically necessary.