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| Case Number: | CM14-0002019 | | |
| Date Assigned: | 04/04/2014 | Date of Injury: | 06/13/2012 |
| Decision Date: | 05/08/2014 | UR Denial Date: | 12/13/2013 |
| Priority: | Standard | Application Received: | 01/07/2014 |

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 Neurology and is licensed to practice in Arizona. 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 37-year-old female who works as an apartment housekeeper who sustained direct trauma to her neck, left shoulder and arm from a ceiling fan that fell on June 28, 2011. Since then, she has been without cervical and shoulder discomfort to some degree, has undergone imaging studies and an upper extremity electromyography (EMG). She has been treated with pain medication, predominately Tramadol (Ultram). Additionally, she reported that she had chronic cough and intermittent dyspnea which she relates to exposure to chemical solvents. This has apparently continued since date of reporting. On her Initial Evaluation Treatment Report of the Primary Treating Physician dated Dec 2, 2013 and subsequent progress reports dated 01/06/14 and 02/17/14 the patient's physical examination finding did not change to include the same neurologic findings of 'global hypoesthesia to pinwheel in the left upper extremity in non-dermatome fashion.' On the Initial Evaluation Treatment Report, it is documented that the patient's lung exam is 'clear to auscultation without wheezing, rhonchi or rales'. Cervical MRI reported on Initial Evaluation Treatment Report of the Primary Treating Physician dated Dec 2, 2013 states 'there was mild disc degeneration at C6-7 and 3.5mm left posterolateral disc protrusion resulting in mild left C6-7 foraminal encroachment and left paracentral canal stenosis. There was straightening of the mid cervical spine'. An Electromyogram Report dated Dec 6, 2012 states 'this is a normal study; there is no electrodiagnostic evidence of cervical radiculopathy or severe peripheral neuropathy; however, this examination cannot detect common causes of radicular symptoms such as nerve root irritation / inflammation from disc protrusion or small fiber neuropathies.' Additionally, an Electro-Diagnostic Interpretation dated Dec 18, 2012 documents; 'This is an unremarkable electrodiagnostic exam. There was no clear evidence of generalized peripheral neuropathy, distal entrapment neuropathy or proximal neural insult.'

IMR ISSUES, DECISIONS AND RATIONALES

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

1 C6-7 SELECTIVE TRANSFORAMINAL EPIDURAL STEROID INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174, Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 46.

Decision rationale: Cervical epidural corticosteroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatome distribution with corroborative findings of radiculopathy with current guidelines recommend no more than 2 ESI (epidural steroid injections). Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. However, cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain that "must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing" with the procedure performed under fluoroscopy for guidance. Repeated ESI treatment "should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year". The MTUS guidelines are specific as to what must be demonstrated in order to obtain an ESI. The patient may express that she is experiencing radicular symptoms; however, neither her MRI nor her EMG studies demonstrate collaborative findings of radiculopathy. Because she does not meet the MTUS guidelines to authorize this treatment is not medically necessary.

TRAMADOL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 82, 93-94.

Decision rationale: Tramadol is a synthetic opioid affecting the central nervous system, is indicated for moderate to severe pain and is not classified as a controlled substance by the DEA. It is considered as a second-line treatment. The immediate release formulation is recommended at a dose of 50 to 100mg PO every 4 to 6 hours (not to exceed 400mg/day). This dose is recommended after titrating patients up from 100mg/day, with dosing being increased every 3 days as tolerated. For patients in need of immediate pain relief, which outweighs the risk of non-tolerability the initial starting dose, may be 50mg to 100mg every 4 to 6 hours (max 400mg/day).

Toxicology testing on 01/09/2014 and on 03/31/14 (reported on 04/03/14) states. 'Ultram is indicated for this patient and was not detected. This could be due to not taking medication as prescribed or to one's metabolism'. This is a rather interesting finding if the patient has been compliant with taking her medication as prescribed. Either the patient is capable of metabolizing Tramadol to the point of non-detection or the medication is not being utilized as intended. A review of Tramadol's metabolism and elimination, 'Tramadol and its metabolites are excreted mainly by the kidneys, with a cumulative renal excretion (Tramadol and metabolites) of approximately 95%. In young adults approximately 15 - 19% of an administered dose of Tramadol is excreted in the urine as unmetabolized drug. In the elderly, this increases to about 35%'. As the patient is neither of these categories, some level of metabolite should be detected in her urine. As the evidence points to non-compliance the continuation of a medication that, via the evidence of negative urine toxicology screening, is not being utilized, is not medically necessary.

1 PULMONARY FUNCTION TEST WITH BRONCHODILATOR: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pulmonary Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pulmonary (Acute and Chronic), Pulmonary Functions Testing.

Decision rationale: Pulmonary function testing is recommended in asthma, the diagnosis, management and prognosis of lung diseases, as a pre-operative evaluation assessment of pulmonary patients. It is separated into simple spirometry and complete pulmonary function testing. The simple spirometry will measure the forced vital capacity (FVC) and provides a variety of airflow rates such as the forced expiratory volume in one second (FEV1) and the forced expiratory flow between 25-75% of the total exhaled volume (FEF25-75). The complete pulmonary function test (PFT) adds tests of the lung volumes and the diffusing capacity for carbon monoxide (DLCO). Other tests of pulmonary function useful in asthma include the spirometry before and after the use of a bronchodilator. Despite the absence of physical exam finding by the requesting physician, because of the patient's history of cleaning agent / chemical solvent exposure, she should undergo pulmonary function testing to determine if any level of reversible or permanent pulmonary function loss has occurred. The request is medically necessary and appropriate.