

Case Number:	CM14-0006898		
Date Assigned:	02/07/2014	Date of Injury:	02/05/1999
Decision Date:	07/07/2014	UR Denial Date:	01/07/2014
Priority:	Standard	Application Received:	01/17/2014

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 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 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:

The patient is a 57-year-old male who has submitted a claim for probable L4 compression fracture, healed, and lumbar discopathy at L3-L4 and L4-L5 associated with an industrial injury date of February 5, 2009. Medical records from 2013-2014 were reviewed, the latest of which, dated January 23, 2014, revealed that the patient complains of low back pain with radiation down the hips and lower extremities. He notes numbness in both lower extremities to about ankle level that resolves with stretching. Prolonged sitting or standing exacerbates the pain. Pain increases when he lies on his back. There is intermittent numbness in the knees when he lies on his side. He rates his pain as 6/10. The patient takes tramadol three times daily, and notes the medication helps with his pain. He tried physical therapy and massage therapy but recalls temporary relief. The pain has returned to baseline. On physical examination, the patient ambulates without assistance. Hypertonicity of the lower lumbar paraspinal musculature was noted. There is limitation in range of motion of the lumbar spine in flexion to approximately 70 degrees, extension to approximately 30 degrees, rotation and lateral flexion limited by about 50%. MRI of the lumbar spine done last January 8, 2014 revealed multilevel degenerative disc disease; there is no critical spinal or foraminal stenosis; there is no evidence of a focal disc protrusion or neural impingement; dorsal annular fissure at L4-L5 and L5-S1 are potential pain generators; and chronic L4 compression fracture/large Schmorl's node. Treatment to date has included massage therapy, physical therapy, home exercise program, and medications which include ibuprofen, flexeril, tramadol and gabapentin. Utilization review from January 7, 2014 denied the request for INITIAL EVALUATION AT THE [REDACTED] FUNCTIONAL RESTORATION PROGRAM QTY:1 because there is no documentation of failure of conservative treatment including home exercise program, physical therapy and NSAIDs, the goals of the function restoration programs are not documented and there is no documentation of

objective measurements of baseline function; denied the request for MRI LUMBAR SPINE QTY:1 because there is no documentation of emergence of red flags; and modified the request for TRAMADOL 50MG QTY:60 to QTY: 20 because there is no documentation of objective evidence of functional benefit and there is no available clinical information which documents the failure of first-line oral analgesics.

IMR ISSUES, DECISIONS AND RATIONALES

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

INITIAL EVALUATION AT THE [REDACTED] FUNCTIONAL RESTORATION PROGRAM QTY:1: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines RESTORATION PROGRAMS (RFPS) Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program Page(s): 31-32.

Decision rationale: As stated on pages 31-32 of the CA MTUS Chronic Pain Medical Treatment Guidelines, functional restoration program participation may be considered medically necessary when all of the following criteria are met: an adequate and thorough evaluation including baseline functional testing; previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; there is significant loss of ability to function independently; the patient is not a candidate where surgery or other treatments would clearly be warranted; the patient exhibits motivation to change; and negative predictors of success have been addressed. In this case, the request for functional restoration program was initially denied. An appeal, dated February 2, 2014, cited that the patient has undergone conservative therapy such as physical therapy and massage therapy, however, with only temporary benefits. He continues to have functional limitations related to his chronic low back pain. He appears to have failed coping skills with regards to chronic pain and this has led to further functional decline. The patient does not have any negative predictors of success. The medical necessity of functional restoration program has been established. Therefore, the request for INITIAL EVALUATION AT THE [REDACTED] FUNCTIONAL RESTORATION PROGRAM QTY:1 is medically necessary.

MRI LUMBAR SPINE QTY:1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296-297.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: According to pages 303-304 of the ACOEM Practice Guidelines referenced by CA MTUS, imaging of the lumbar spine is supported in patients with unequivocal objective findings that identify specific nerve compromise on the neurologic examination, and who do not

respond to treatment, and who are in consideration for surgery. MRI of the lumbar spine done last January 8, 2014 revealed multilevel degenerative disc disease; there is no critical spinal or foraminal stenosis; there is no evidence of a focal disc protrusion or neural impingement; dorsal annular fissure at L4-L5 and L5-S1 are potential pain generators; and chronic L4 compression fracture/large Schmorl's node. In the most recent clinical evaluation, there is no documentation of new injury or trauma to the lumbar spine. Also, there is no worsening of subjective complaints and objective findings that may warrant further investigation by utilizing MRI. Therefore, the request for MRI of the LUMBAR SPINE QTY:1 is not medically necessary.

TRAMADOL 50MG QTY:60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 88,89,93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113.

Decision rationale: As stated on page 113 of the CA MTUS Chronic Pain Medical Treatment Guidelines, tramadol is not recommended as a first-line oral analgesic. In this case, tramadol was prescribed last December 18, 2013. The patient takes tramadol three times daily, and notes the medication helps with his pain. However, there is no documentation of failure of first-line oral analgesics. There is no clear indication at this time to necessitate adjunct opioid treatment in this case. Also, utilization review, dated January 31, 2014, certified the request for Tramadol HCl ER 150mg trial QTY: 30. Therefore, the request for TRAMADOL 50MG QTY:60 is not medically necessary.