MAXIMUS Federal Services

| Case Number: | CM14-0154235 | | |
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| Date Assigned: | 09/23/2014 | Date of Injury: | 11/09/2007 |
| Decision Date: | 10/24/2014 | UR Denial Date: | 09/10/2014 |
| Priority: | Standard | Application Received: | 09/22/2014 |

## 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Management 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 injured worker is a 57-year-old male who reported an injury when a door fell on him on 11/09/2007. On 05/08/2014, his diagnoses included right shoulder impingement/bursitis, right shoulder AC arthrosis, left shoulder impingement/bursitis, left shoulder tendinosis, left shoulder AC arthrosis, right elbow lateral epicondylitis, right elbow DJD, left elbow lateral epicondylitis, right knee chondromalacia, and right knee effusion. On 01/06/2014, he underwent a right shoulder arthroscopic subacromial decompression with distal clavicle resection. The treatment plan included chiropractic therapy postoperatively on the left shoulder twice a week for 6 weeks. On 08/06/2014, it was noted that he had completed 16 sessions of chiropractic therapy, which aggravated his pain. "He felt that his discs were popping." His diagnoses included cervical degenerative disc disease, cervical spine herniation, cervical stenosis, thoracic spine degenerative disc disease and lumbar spine disc herniation. The treatment plan included a recommendation for an MRI of the thoracic spine to evaluate his increased pain complaints. His medications included Norco 7.5/325 mg, tramadol ER 150 mg, Flexeril 7.5 mg, and LidoPro cream. A request for authorization dated 08/06/2014 was included in this worker's chart.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of Thoracic Spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, MRIs

**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, Lumbar & Thoracic, MRIs.

**Decision rationale:** The California MTUS/ACOEM Guidelines recommend that relying solely on imaging studies to evaluate the source of low back pain and related symptoms carries a significant risk of diagnostic confusion, including false positive test results because of the possibility of identifying a finding that was present before symptoms began and therefore had no temporal association with the symptoms. False positive results have been found in up to 50% of those over age 40. The Official Disability Guidelines recommend that MRI for uncomplicated low back pain with radiculopathy is not recommended until after at least 1 month of conservative therapy. Conservative care includes a self-performed exercise program as an extension of prior physical therapy that included ongoing back strengthening and flexibility exercises as well as aerobic exercises and recommended appropriate drug therapies which includes trials of antidepressants and/or anticonvulsants in conjunction with analgesics. MRIs are recommended for uncomplicated low back pain prior to lumbar surgery. An indication for magnetic resonance imaging of the thoracic spine includes thoracic spine trauma with neurological deficits. There was no evidence in the submitted documentation of this injured worker continuing a home exercise program or that he had failed trials of antidepressants and/or anticonvulsants. There was no evidence that he was a surgical candidate. The clinical information submitted failed to meet the evidence based guidelines for MRI. Therefore, this request for MRI of thoracic spine is not medically necessary.

**Tramadol 150MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol (Ultram) Page(s): 74-95, 113.

**Decision rationale:** The California MTUS Guidelines recommend ongoing review of opioid use including documentation of pain relief, functional status, appropriate medication use, and side effects. It should include current pain and intensity of pain before and after taking the opioid. In most cases, analgesic treatment should begin acetaminophen, aspirin, NSAIDs, antidepressants, and/or anticonvulsants. There was no documentation in the submitted chart regarding appropriate long term monitoring/evaluations including side effects, failed trials of NSAIDs, aspirin, antidepressants or anticonvulsants, quantified efficacy or drug screens. Additionally, there was no frequency specified in the request. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first line oral analgesic. Furthermore, the request did not specify the extended release form of tramadol. Therefore, this request for Tramadol 150 mg #30 is not medically necessary.