

<b>Case Number:</b>	CM14-0155105		
<b>Date Assigned:</b>	10/27/2014	<b>Date of Injury:</b>	10/09/2002
<b>Decision Date:</b>	11/25/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 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 59-year-old male who reported an injury on 10/09/2002. The mechanism of injury was not submitted for review. The injured worker has diagnoses of herniated nucleus pulposus, degenerative disc disease at L5-S1 with radiculopathy, morbid exogenous obesity, severe depression, insomnia, and dizziness. Past medical treatment consists of medication therapy. Medications consist of topical Gabapentin/Ketoprofen, Xanax, Prilosec, Flexeril, and tramadol. On 07/23/2014, the injured worker underwent an MRI of the lumbar spine which revealed there was levoscoliosis, lordosis and alignment were maintained, and no paravertebral soft tissue abnormalities. On 08/26/2014, the injured worker complained of moderate low back pain. Straight leg was positive sitting at 90 degrees bilaterally, and straight leg raise was positive at 60 degrees lying bilaterally. There were no documented findings of motor strength, sensory deficits, or range of motion. The medical treatment plan is for the injured worker to continue with medication therapy, see a spine surgeon, undergo an MRI of the lumbar spine, and undergo EMG/NCV of the lower extremities bilaterally. A rationale was not submitted for review. The Request for Authorization form was submitted on 07/15/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol 150mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Ongoing management Page(s): 82, 93, 94, 113 and 78.

**Decision rationale:** The California MTUS states that central analgesic drugs, such as tramadol, are reported to be effective in managing neuropathic pain. It is not recommended as a first line oral analgesic. The California MTUS recommends that there should be documentation of the 4 A's for ongoing monitoring (including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). An assessment should include what pain levels were before, during, and after medication administration. The submitted documentation did not indicate that the injured worker had any neuropathic pain. Additionally, there was no evidence of the injured worker having a diagnosis congruent with the above guidelines. Furthermore, there was no indication of the efficacy of the medication, nor whether the medication was helping with any functional deficits. A urinalysis submitted on 08/26/2014 showed that the injured worker was in compliance with his medications. However, there was no indication of what pain levels were before, during, and after medication administration. Given the above, the injured worker is not within MTUS recommended guidelines. As such, the request is not medically necessary.

**Spine surgeon consultation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 228.

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

**Decision rationale:** The California MTUS Guidelines state that if the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The submitted documentation did not provide any evidence that the current treatment had resulted in failed or improvement in complaints. Based on the submitted documentation reviewed and medical guidelines, a consultation to a surgeon would not be indicated. As such, the request is not medically necessary.

**MRI of the Lumbar spine.:** 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 rationale:** The CA MTUS/ACOEM Guidelines state that unequivocal objective findings identifying specific nerve compromise on the neurological exam are sufficient evidence to warrant imaging in patients who do not respond to treatment. However, it is also stated that when the neurological exam is less clear, further physiologic evidence of nerve dysfunction

should be obtained before ordering an imaging study. The included medical documents failed to show evidence of significant neurologic deficits on physical examination. Additionally, documentation failed to show the injured worker had trialed and failed an adequate course of conservative treatment. Furthermore, submitted for review was an MRI of the Lumbar spine which was obtained on 07/23.2014. There was no rationale submitted to warrant a repeat MRI. In the absence of documentation showing the failure of initially recommended conservative care, including active therapies and neurologic deficits on physical exam, a repeat MRI is not supported by referenced guidelines. Given the above, the injured worker is not within the recommended guidelines criteria. As such, the request is not medically necessary.

**Electromyography (EMG) 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 rationale:** The CA MTUS/ACOEM states that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting for more than 3 to 4 weeks. The submitted documentation did not indicate any neurologic deficits pertaining to the injured worker's lumbar spine. The clinical note revealed that the injured worker had a positive straight leg raise. However, there was no evidence of sensation, motor strength, or reflex deficits. Furthermore, there was no indication of failure of conservative care treatment. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

**Nerve conduction velocity (NCV) Bilateral Lower Extremities: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, NCV of the lower extremities.

**Decision rationale:** The Official Disability Guidelines state that an NCV is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The submitted documentation did not indicate any neurologic deficits pertaining to the injured worker's lumbar spine. The clinical note revealed that the injured worker had a positive straight leg raise. However, there was no evidence of sensation, motor strength, or reflex deficits. Furthermore, there was no indication of failure of conservative care treatment. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.