

Case Number:	CM14-0026645		
Date Assigned:	06/13/2014	Date of Injury:	09/29/2010
Decision Date:	07/16/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	03/03/2014

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 Anesthesiology has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 45 year old female injured on 09/29/10 due to undisclosed mechanism of injury. Clinical note dated 02/10/14 listed the current diagnoses as lumbar spondylosis with previous MRI of the lumbar spine in 2010. The injured worker was approved for chiropractic therapy and requires updated MRI to start treatment. The injured worker presented complaining of low back pain and requesting medication refills. The injured worker also reported difficulty sleeping on her side at night and waking up reporting numbness, tingling, and weakness in bilateral upper extremities and shoulders. The injured worker reported improved activities of daily living with approximately 50% reduction in pain with prior physical therapy. Prior MRI on 11/10/10 revealed mild degenerative disc disease at L4-5 with disc desiccation and slight disc space narrowing, and small left paracentral disc protrusion resulting in mild minimal left sided central canal narrowing. The injured worker rated her pain 7/10. Physical examination of the lumbar spine revealed limited range of motion, tenderness to palpation of lumbar paraspinal muscles, positive tenderness of facet joints, decreased strength to left lower extremity, sensation intact, and reflexes symmetrical intact to bilateral lower extremities. Medications included Ultram 50mg three times a day and Voltaren 75mg twice a day. The initial request for Ultram 50mg one tab every eight to twelve hours as needed #60 plus one refill and updated MRI lumbar spine without contrast was initially non-certified on 02/18/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

ULTRAM 50 MG ONE TAB EVERY 8-12 HOURS AS NEEDED #60 PLUS ONE REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: Patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Ultram 50 mg one tab every 8-12 hours as needed #60 plus one refill cannot be established at this time.

UPDATED MRI LUMBAR SPINE WITHOUT CONTRAST: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Medical Treatment Guidelines-online version, Low Back Complaints, Magnetic Resonance Imaging (MRI).

Decision rationale: Magnetic Resonance Imaging (MRI) is not recommended in cases of uncomplicated low back pain, with radiculopathy, until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). The clinical documentation fails to establish compelling objective data to substantiate the presence of radiculopathy or neurologic deficit. As such, the request for updated MRI lumbar spine without contrast cannot be recommended as medically necessary.