

<b>Case Number:</b>	CM14-0198303		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	02/01/2003
<b>Decision Date:</b>	01/22/2015	<b>UR Denial Date:</b>	11/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Family Practice 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:

This is a 55 year old male patient who sustained a work related injury on 2/1/2003. Patient sustained the injury when he was mopping a floor and the mop apparently became caught in a food cart, and he had a wrenching-like sensation in his low back and developed complaints of low back and left lower extremity pain. The current diagnoses include lumbar disc displacement without myelopathy, sciatica, depression and disorders sacrum. Per the doctor's note dated 11/26/14, patient has complaints of low back pain at 9/10 with radicular symptoms into his left lower extremity and pain was better with rest as well as walking slowly. He continued to utilize a cane for assistance with ambulation. Physical examination revealed deep tendon reflexes were symmetrical bilaterally to the patella and Achilles, no clonus sign, normal lumbar flexion, extension, bilateral lateral bending and rotation to the right and left, sensation was decreased in the dermatome(s) left L4, straight leg raise was negative, spasm and guarding in the lumbar spine and lumbar spine motor strength was 5/5. The current medication lists include Norco, Tramadol, Docusate Sodium, Hydrochlorothiazide, Metformin, Vitamin D and Novolin. The patient has had MRI of the low back on 11/27/07 that revealed mild degenerative changes; at L5-S1 minimal central bulge, normal central canal and lateral recesses, minimal bilateral intervertebral neural foraminal narrowing; MRI of the left knee which revealed medial compartment changes and extensive meniscal tearing. He was given lumbar epidural steroid injections and this helped for some time. The patient's surgical history include right total knee replacement in 2002, left total knee replacement in 2007, lumbar facet blocks and lumbar discography at the L4-5 and L5-S1 levels and a left hernia operation on 11/4/14. He had undergone a course of acupuncture. The patient has received an unspecified number of the PT visits for this injury.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **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): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Official Disability Guidelines Treatment in Workers' Comp., online Edition Chapter: Low Back (updated 11/21/14) MRIs (magnetic resonance imaging)

**Decision rationale:** Per the ACOEM low back guidelines cited below "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures)." ACOEM/MTUS guideline does not address a repeat MRI. Hence ODG is used. Per ODG low back guidelines cited below, "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, neuro compression, and recurrent disc herniation)." The patient has had MRI of the low back on 11/27/07 that revealed mild degenerative changes; at L5-S1 minimal central bulge, normal central canal and lateral recesses, minimal bilateral intervertebral neural foraminal narrowing. Any significant changes in objective physical examination findings since the last MRI that would require a repeat MRI study were not specified in the records provided. Patient did not have any evidence of severe or progressive neurologic deficits that are specified in the records provided. Any finding indicating red flag pathologies were not specified in the records provided. The history or physical exam findings did not indicate pathology including cancer, infection, or other red flags. As per records provided patient has received an unspecified number of PT and aquatic visits for this injury till date. A detailed response to complete course of conservative therapy including PT visits was not specified in the records provided. Previous PT visit notes were not specified in the records provided. A recent lumbar spine X-ray report is not specified in the records provided. A plan for an invasive procedure of the lumbar spine was not specified in the records provided. The medical necessity of the MRI OF THE LUMBAR SPINE is not fully established for this patient.

### **TRAMADOL 50MG #90:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Central acting analgesics; Opioids for neuropathic pain Page(s): 75; 82.

**Decision rationale:** Tramadol is a centrally acting synthetic opioid analgesic. According to MTUS guidelines "Central acting analgesics: an emerging fourth class of opiate analgesic that may be used to treat chronic pain. This small class of synthetic opioids (e.g., Tramadol) exhibits opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Central analgesics drugs such as Tramadol (Ultram) are reported to be effective in managing neuropathic pain. (Kumar, 2003)" Cited guidelines also state that, "A recent consensus guideline stated that opioids could be considered first-line therapy for the following circumstances: (1) prompt pain relief while titrating a first-line drug; (2) treatment of episodic exacerbations of severe pain; [&] (3) treatment of neuropathic cancer pain." Per the doctor's note dated 11/26/14, patient has complaints of low back pain at 9/10 with radicular symptoms into his left lower extremity and pain was better with rest as well as walking slowly. He continued to utilize a cane for assistance with ambulation. Physical examination revealed sensation was decreased in the dermatome(s) left L4 and spasm and guarding in the lumbar spine. The patient has had MRI of the low back on 11/27/07 that revealed mild degenerative changes; at L5-S1 minimal central bulge, normal central canal and lateral recesses, minimal bilateral intervertebral neural foraminal narrowing; MRI of the left knee which revealed medial compartment changes and extensive meniscal tearing. The patient's surgical history include right total knee replacement in 2002, left total knee replacement in 2007, lumbar facet blocks and lumbar discography at the L4-5 and L5-S1 levels and a left hernia operation on 11/4/14. Tramadol can be used for chronic pain and for treatment of episodic exacerbations of severe pain. The patient has chronic pain and the patient medical condition can have intermittent exacerbations. Having tramadol available for use during sudden unexpected exacerbations of pain is medically appropriate and necessary. This request for TRAMADOL 50MG #90 is deemed as medically appropriate and necessary.