

Case Number:	CM14-0206152		
Date Assigned:	12/18/2014	Date of Injury:	04/12/2003
Decision Date:	02/12/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/09/2014

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 Rehab, 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 female with date of injury 4/12/03. According to the utilization review report the treating physician report dated 11/17/14 (not included) indicates that the patient presents with pain affecting bilateral neck, low back and right upper limb. The physical examination findings reveal restricted ROM of the cervical and lumbar spine and right wrist along with cervical and lumbar muscle spasms. Cervical discogenic, lumbar and right wrist provocative maneuvers were positive. Prior treatment history includes medication. According to the comprehensive medical-legal evaluation report on 12/18/14 (15) the current diagnoses are: 1.Large right C5-C6 uncinated spur causing severe right foraminal stenosis 2.Right wrist distal radial fracture status post open reduction, internal fixation 3.Chronic right upper limb and right hand and wrist pain 4.Right wrist degenerative arthritis 5.Chronic cervical, thoracic and lumbar back pain 6.Cervical degenerative disc disease, C6-C7 The utilization review report dated 12/02/14 denied the request for tramadol 37.5/325 mg #90 based on the patient finishing an opioid detox program as well as first-line analgesics have not been tried. Also denied were chiropractic x 8 treatments for cervical, thoracic and lumbar spine based on chiropractic care being recommended for flare-ups based on objective evidence of functional improvement with prior treatment but no such evidence of prior treatment was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 37.5/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-77 and 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 88 and 89.

Decision rationale: The patient presents with bilateral neck, lower back and right upper limb pain. The current request is for tramadol 37.5/325 mg #90. The treating physician states that the patient completed the HELP program, which included opioid detoxification for this patient. The MTUS guidelines state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief." In this case, the treating physician has provided virtually no documentation to review. There is no way of knowing if non-opioid treatments have been attempted as a first line of treatment. MTUS on page 60 requires documentation of pain and function when prescribing medication for chronic pain. There is no discussion of a treatment plan, functional goals or expected duration of use. Therefore, this request is not medically necessary.

Chiropractic x 8 treatments for the cervical, thoracic, and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58 and 59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58 and 59.

Decision rationale: The patient presents with bilateral neck, lower back and right upper limb pain. The current request is for chiropractic x 8 treatments for cervical, thoracic and lumbar spine. The comprehensive medical-legal evaluation report dated 12/18/14 states that the patient had chiropractic treatments over two years ago that provided 75 percent relief for over three months. The MTUS guidelines state that manual therapy and manipulation are "recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. In this case, the treating physician has not provided information as to objective measurable gains in functional improvement but has just stated there was 75 percent relief for over three months. There is poor documentation and a lack of records to review. The current request does not indicate the total number of chiropractic treatments provided or if this treatment is for a flare-up. The current request for 8 treatments is not medically necessary as the lack of documentation provided does not follow the MTUS guidelines. Therefore, this request is not medically necessary.

