

Case Number:	CM15-0001885		
Date Assigned:	01/12/2015	Date of Injury:	03/03/1998
Decision Date:	03/16/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Colorado

Certification(s)/Specialty: Family Practice

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 56 year old male who sustained a work related injury to his neck, lower back and upper extremities while employed as a truck driver on March 3, 1998. He is diagnosed with post lumbar laminectomy syndrome with myelopathy, lumbago, shoulder pain, cervicalgia and degeneration of the cervical intervertebral disc. The injured worker underwent bilateral shoulder surgeries, four back surgeries and a spinal cord stimulator implant. There are no documented dates of the surgical interventions or procedure descriptions. The patient continues to experience aching, continuous low back pain, left shoulder and neck pain. Current medications consist of Tramadol ER, Fioricet and Neurontin. Recent treatment modalities to date consist of chiropractic therapy, physical therapy, epidural steroid injection (ESI), pain management, home exercise program, stretches and moist heat. The injured worker is Permanent & Stationary (P&S).The treating physician requested authorization for 1 updated CT scan of the cervical spine without contrast and Tramadol HCL ER 150mg #120 for ongoing pain management. On December 11, 2014 the Utilization Review denied certification for 1 updated CT scan of the cervical spine without contrast and Tramadol HCL ER 150mg #120. Citation used in the decision process for Tramadol was the Medical Treatment Utilization Schedule (MTUS), Chronic Pain Guidelines. The American College of Occupational and Environmental Medicine (ACOEM) Neck and Upper Back Complaints and the Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic), Indications for Computed Tomography (CT) were referenced.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Updated CT scan of the cervical spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 4-5.

Decision rationale: The MTUS Guidelines do not address the use of Advanced Imaging, so the ACOEM Guidelines were consulted. As the patient of concern has a spinal cord stimulator in place, he cannot undergo MRI, so CT has been requested to accomplish the goal of soft tissue / neural imaging. Therefore, in this situation the Guidelines for MRI are actually the applicable recommendations as the indications for MRI would be the indications for CT here. MRI or CT can be recommended (though evidence is limited to support) for patients with: Acute cervical pain with progressive neurologic deficit; Significant trauma with no improvement in significantly painful or debilitating symptoms; A history of neoplasia (cancer), Multiple neurological abnormalities that span more than one neurological root level; Previous neck surgery with increasing neurologic symptoms; Fever with severe cervical pain; Symptoms or signs of myelopathy; or Subacute or chronic radicular pain syndromes lasting at least 4 to 6 weeks in whom dermatomal and myotomal symptoms are not trending towards improvement if either injection is being considered or both the patient and surgeon are considering early surgical treatment if supportive findings on MRI / CT are found. MRI / CT is not recommended for non-specific neck pain. MRI / CT is not recommended for acute radiculopathy, unless patient has progressive neurological symptoms or severe impairment, and injections or early surgical intervention are being considered. For the patient of concern, the records do not establish that patient has neurological deficits on exam, only complaints that could be radicular by history. The 11/24/2014 office visit with the treating physician notes a normal neurological exam of the upper extremities and does not mention patient's numbness / tingling / weakness of the upper extremities, until the end of the note when CT is requested. (Not included in patient's HPI) No documentation is supplied that indicates a new procedure (injections or other) is being considered. Based on the Guidelines and lack of evidence that patient has neurological abnormalities / acute findings that require further imaging to define/treat, the CT of Cervical Spine is not medically necessary.

Tramadol HCL ER 150mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 79-80, 85, 88-89, and 93.

Decision rationale: Tramadol is a synthetic opioid that exerts its effect on the central nervous system. The MTUS Guidelines establish criteria for use of opioids, including long term use (6

months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated clinical assessment tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence" or misuse. Per the Guidelines, Chelminski defines "serious substance misuse" as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work? Has patient had improved function and decreased pain with the opioids? For the patient of concern, there is documentation that patient's pain is improved with his current regimen which has included Tramadol for over 6 months. (Pain rating 7/10 without medications and 1/10 with medications, on 3 visits in last 6 months) The treating physician also indicates that pain medications help patient accomplish activities of daily living, mobility, and home exercises. There is no objective assessment of function documented in the record in the last 6 months. The records refer to monitoring of medications with urine drug screens, but these are not supplied in the records for review. The treating physician indicates that multiple medications have been tried and failed, though specifics not listed except for certain hydrocodone formulations, and the patient continues on as needed non-steroidal anti-inflammatory drugs, so not clear what else patient cannot tolerate. The record indicates that patient had "severe" reactions to some other

options for pain, but then does not specify which medications or what reactions. While the documentation supports that the patient has improved pain with the Tramadol included in his regimen, there is no objective assessment of improved function and no urine drug screens supplied for review to verify monitoring is being accomplished. The Tramadol therefore is not medically indicated.