

<b>Case Number:</b>	CM15-0004487		
<b>Date Assigned:</b>	01/15/2015	<b>Date of Injury:</b>	09/22/2014
<b>Decision Date:</b>	12/22/2015	<b>UR Denial Date:</b>	12/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 55 year old female who sustained an industrial injury on 9-22-14. A review of the medical records indicates that the worker is undergoing treatment for lumbar spine musculoligamentous sprain-strain with bilateral lower extremity radiculitis, bilateral sacroiliac joint sprain, cervical spine musculoligamentous sprain-strain, left shoulder periscapular sprain-strain, and gastrointestinal irritation- deferred to specialist. Subjective complaints (11-24-14) include low back pain radiating to the bilateral extremities, neck pain, left shoulder pain, and gastrointestinal complaints secondary to medication use. Objective findings (11-24-14) include cervical spine tenderness to palpation with spasm-muscle guarding over paravertebral musculature and trapezius muscles, lumbar tenderness to palpation with muscle spasm and guarding over paravertebral musculature and sacroiliac joints, positive straight leg raise on the left, left shoulder tenderness, positive impingement and cross arm tests, lumbar spine range of motion in degrees is: flexion 22, extension 11, right and left side bending is 16, and sensation to pinprick and light touch in bilateral hands and feet is decreased. "Radiographs of the cervical spine demonstrate slight degenerative changes at C5-C6. Radiographs of the left shoulder are within normal limits." Work status was noted as temporary total disability. On 12-14-14, the requested treatment of chiropractic therapy was modified to a quantity of 6 (request was for 8), Ultram ER 150mg, Fexmid 7.5mg, diagnostic ultrasound left shoulder, and internal medicine consultation was denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic therapy x 8: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** Regarding the request for chiropractic care, the Chronic Pain Medical Treatment Guidelines state on pages 58-60 the following regarding manual therapy & manipulation: "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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care: Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care: Not medically necessary. Recurrences/flare-ups: Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines a. Time to produce effect: 4 to 6 treatments; b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks; c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined." In the case of this injured worker, there is no comprehensive summary of chiropractic to date or functional benefit from prior chiropractic treatment. If this is an initial request, then it exceeds guideline recommendations which specify for an initial trial of up to 6 visits. Given these factors, this request is not medically necessary.

**Ultram ER 150mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, specific drug list.

**Decision rationale:** Tramadol is a centrally acting opioid agonist and also inhibits the reuptake of serotonin and norepinephrine. On July 2, 2014, the DEA published in [REDACTED] the final rule placing tramadol into schedule IV of the Controlled Substances Act. This rule will

became effective on August 18, 2014. The CPMTG specifies that this is a second line agent for neuropathic pain. Given its opioid agonist activity, it is subject to the opioid criteria specified on pages 76-80 of the CPMTG. With regard to this request, the California Chronic Pain Medical Treatment Guidelines state the following about on-going management with opioids: "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the '4 A's' (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). 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." Guidelines further recommend discontinuing opioids if there is no documentation of improvement in function and reduction in pain. In the progress reports available for review, the requesting provider did not adequately document monitoring of the four domains. Improvement in function was not clearly outlined. This can include a reduction in work restrictions or significant gain in some aspect of the patient's activities. Furthermore, there was no discussion regarding possible aberrant drug-related behavior. Although this appears to be an initial prescription by this requesting provider, since this request for authorization was dated 11/24/14 which coincides with the date of the first report of occupational injury, there should have been some discussion as to function or aberrant behaviors if this medication is a continuation of a prior med. Based on the lack of documentation, medical necessity of this request cannot be established at this time. Although tramadol is not medically necessary at this time, it should not be abruptly halted, and the requesting provider should start a weaning schedule as he or she sees fit or supply the requisite monitoring documentation to continue this medication.

**Fexmid 7.5mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** Fexmid is a brand name for cyclobenzaprine. Regarding the request for cyclobenzaprine, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Given this, the current request is not medically necessary.

**Diagnostic ultrasound for left shoulder: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Summary.

**Decision rationale:** Regarding the request for ultrasound of the shoulder, the ACOEM Shoulder Complaints Chapter (adopted by California MTUS) cites that ultrasonography for evaluation of rotator cuff is not recommended. Within the documentation available for review, there is no documentation of subjective/objective findings consistent with a condition/diagnosis for which ultrasound is supported given the lack of support for its use in the evaluation of the rotator cuff. In the Doctor's First Report of Occupational Injury, there is no clear summary of conservative treatments to date for the shoulder, and imaging is usually reserved following some conservative care. Furthermore, there is a dispute as to whether the shoulder region is industrially related. Given this, the current request is not medically necessary.

**Internal medicine consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, 2nd Edition, (2004), Independent Medical Examinations and Consultations, Chapter 7, Page 127.

**Decision rationale:** With regard to the request for specialty consultation, the CA MTUS does not directly address specialty consultation. The ACOEM Practice Guidelines Chapter 7 recommend expert consultation when; "when the plan or course of care may benefit from additional expertise." Thus, the guidelines are relatively permissive in allowing a requesting provider to refer to specialists. However, in this case, the rationale for internal medicine consultation is not made clear. The patient has principally musculoskeletal complaints, and there are no industrially related internal medicine concerns apparent from a review of the records. Given this, this request is not medically necessary.