

<b>Case Number:</b>	CM15-0101821		
<b>Date Assigned:</b>	06/04/2015	<b>Date of Injury:</b>	11/06/2012
<b>Decision Date:</b>	07/10/2015	<b>UR Denial Date:</b>	05/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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 injured worker is a 57-year-old male, who sustained an industrial injury on 11/6/2012. He reported being involved in a motor vehicle accident. Diagnoses have included traumatic disc herniation C5 and C6 with radiculopathy. Treatment to date has included pre-operative physical therapy, anterior cervical discectomy and fusion (ACDF) 2/20/2013 and medication. According to the progress report dated 4/30/2015, the injured worker complained of neck pain rated 6/10. He reported that the neck pain had been increasing over the last six months along with numbness and tingling of the bilateral upper extremities at night and if having to turn his head while driving. Exam of the cervical spine revealed decreased range of motion. Foraminal compression test was positive. There was positive paraspinal tenderness to percussion. Authorization was requested for acupuncture treatment twice a week for six weeks, chiropractic treatment twice a week for six weeks, Naproxen, Omeprazole, a toxicology screen, electromyography (EMG)/nerve conduction velocity (NCV) for bilateral upper extremities, and Tramadol.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture (12-sessions, 2 times a week for 6-weeks): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** Per the MTUS Guidelines, acupuncture can be an option for pain treatment in the following circumstances: When pain medications are to be reduced or cannot be tolerated, when additional therapy is needed in conjunction with physical medicine, to aid in functional recovery after surgery. Acupuncture is intended to decrease pain and inflammation, increase blood flow, and range of motion, reduce anxiety, and decrease muscle spasm. Per the Guidelines, the frequency and duration of acupuncture are as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented. For the patient of concern, the clinical record indicates patient has not been in any treatment for his condition in over 1 year, so first line treatments and therapies have not recently been tried. Patient has not previously participated in Acupuncture, per the records supplied, so the maximum number of treatments that would be recommended to determine efficacy would be 6 treatments. The request for 12 treatments exceeds the recommended maximum for trial of Acupuncture, so the request is not medically necessary.

**Chiropractic (12-sessions, 2 times a week for 6-weeks): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** Per the MTUS, manual manipulation, including chiropractic therapy, can be recommended for certain musculoskeletal conditions. Neck pain is not specifically indicated, but not excluded, so the guidelines can be applied for diagnosis of neck pain. The maximum recommended number of trial sessions is 6, at which time assessment of improvement should be documented if additional chiropractic sessions are desired. Additional chiropractic sessions can be approved after initial trial of 6 sessions, if documented improvement is available. For the patient of concern, there is no documentation of previous chiropractic care. Without documentation of improvement with any previous chiropractic care, 6 chiropractic visits for a trial would be the maximum number recommended. Therefore, the request for 12 chiropractic sessions exceeds the maximum number of recommended initial sessions, so not medically indicated.

**Toxicology Screen: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-80, 94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-78.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, urine drug testing is indicated to monitor opioid use and check for illicit substances that could interfere or interact with the opioids. In this case, opioids are not indicated for this patient. Therefore, the requested urine drug testing is not medically necessary.

**EMG/NCV:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 807-808 and 847-848.

**Decision rationale:** The MTUS Chronic Pain Treatment Guidelines do not address the use of EMG/NCV as diagnostics, so the ACOEM Guidelines were consulted. As EMG and NCV are recommended in combination, the rationale for EMG is the same as that for NCV. Electro diagnostic studies, comprised of EMG and NCV, are recommended when CT or MRI is non-diagnostic and /or patient continues to have symptoms, suggestive of neurological compromise, that do not respond to treatment. If suspected radicular pain fails to resolve or reaches a plateau after 4-6 weeks, which would allow time to develop new abnormalities on testing, then NCV, with needle EMG component if radiculopathy suspected, would be indicated. NCV would also be indicated if another condition, in addition to or instead of radiculopathy, is suspected based on history and/or physical. Some clinicians would wait to test patients with NCV/EMG until after patient failed a steroid injection as a diagnostic and therapeutic trial. For the patient of concern, there is documentation of symptoms including tingling and weakness in upper extremities. The records do not indicate any upper extremity neurologic abnormalities on physical examination, and patient has not had any recent treatment directed toward alleviation of radicular symptoms. There has not yet been updated CT or MRI related to current upper extremity symptoms, and patient does have known history of cervical radiculopathy. Without evidence of neurologic abnormalities on physical examination, or failure of treatment, and with no current CT or MRI, the EMG/NCV would not be medically necessary.

**Tramadol 50mg, 2 times per day as needed, #60 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Tramadol; Opioids, criteria for use, On-going Management; Weaning of Medications Page(s): 76-78, 78-80, 93-94, 124.

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

**Decision rationale:** Per the Guidelines, opioids, including centrally acting synthetic opioid, Tramadol, can be recommended as a second-line treatment (alone or in combination with first-

line drugs) for neuropathic pain, though the studies are not conclusive. In certain situations, opioids, including Tramadol, could be considered first line therapy: (1) prompt pain relief while titrating a first-line drug; (2) treatment of episodic exacerbations of severe pain; [ & ] (3) treatment of neuropathic cancer pain. (Dworkin, 2007). When starting or re-starting opioids, they should be part of a treatment plan for the patient with specific goals / endpoints. (a) Are there reasonable alternatives to treatment, and have these been tried? (b) Is the patient likely to improve? Examples: Was there improvement on opioid treatment in the acute and sub acute phases? Were there trials of other treatment, including non-opioid medications? (c) Is there likelihood of abuse or an adverse outcome? See Substance abuse (tolerance, dependence, addiction). (d) Ask about Red Flags indicating that opioids may not be helpful in the chronic phase: (1) Little or no relief with opioid therapy in the acute and sub acute phases. (2) The patient has had a psychological evaluation and has been given a diagnosis of somatoform disorder. (3) The patient has been given a diagnosis in one of the particular diagnostic categories that have not been shown to have good success with opioid therapy: conversion disorder; somatization disorder; pain disorder associated with psychological factors (such as anxiety or depression). (e) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision. 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). 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 those at high risk of opioid abuse, the following are recommended to prevent misuse/addiction a) Opioid therapy contracts. See Guidelines for Pain Treatment Agreement. b) Limitation of prescribing and filling of prescriptions to one pharmacy. c) Frequent random urine toxicology screens. d) Frequent evaluation of clinical history, including questions about cravings for the former drug of abuse (a potential early sign of relapse). e) Frequent review of medications (including electronic medical record evaluation when f) Communication with pharmacists. g) Communication with previous providers and other current providers, with evidence of obtaining medical records. (It has been recommended that opioids should not be prescribed on a first visit until this step has been undertaken). h) Evidence of participation in a recovery program (12-step or follow-up with a substance abuse counselor), such as speaking to his/her sponsor for the 12-step program. i) Establishment of goals of treatment that can be realistically achieved. j) Initiation of appropriate non-opioid adjunct medications and exercise programs. k) Utilize careful documentation, and in particular, that which is recommended in the State in which opioids are prescribed. l) Incorporate family and friends for support and education. (Chabel,1997) (Michna,2004) (Weaver,2002). Baseline pain and functional assessments to be done prior to opioids prescription, and recheck update as needed. Pain and function should be quantified using a validation tool or numerical scale. For the patient of concern, the records indicate he has not been using any medications except Ibuprofen until the evaluation by Orthopedics included for review. Though not directly verified, the implication in the record is that Tramadol is a new medication for the patient at the time of request. There is no documentation of discussion of goals for opioid therapy, or discussion of side effects of opioid therapy. There is no documentation of discussion of alternatives to opioid therapy or outcomes of previous opioid therapy. Without more thorough documentation of assessment for the patient's suitability for opioid therapy, and clear plan for opioid therapy and monitoring, the Tramadol request is not medically indicated.