

Case Number:	CM15-0136665		
Date Assigned:	07/24/2015	Date of Injury:	05/01/2014
Decision Date:	09/22/2015	UR Denial Date:	07/06/2015
Priority:	Standard	Application Received:	07/14/2015

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 25 year old female, who sustained an industrial injury on 05/01/2014. The injured worker is currently temporarily totally disabled. The injured worker is currently diagnosed as having thoracic spine musculoligamentous sprain/strain, lumbar spine musculoligamentous sprain/strain with radiculitis, and bilateral shoulder tendinosis. Treatment and diagnostics to date has included physical therapy, chiropractic therapy, and use of medications. In a progress note dated 06/10/2015, the injured worker presented with complaints of pain in the mid/upper back (rated 8/10 on the pain scale, which has remained the same since last visit), lower back (rated 9/10, which has increased from 8/10 since last visit), and bilateral shoulders (rated 6/10 in the right shoulder and 5/10 in the left shoulder, which decreased from 6/10 since last visit). Objective findings include tenderness to palpation with restricted range of motion to the thoracic spine, lumbar spine, and bilateral shoulders. The treating physician reported requesting authorization for chiropractic manipulation, Tramadol, and urine toxicology.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic manipulation lumbar & thoracic 3x4: Upheld

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

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

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 functional benefit from prior chiropractic treatment. There is a statement that chiropractic has helped the patient 10% in terms of functionality, but a validated measure of functionality such as the ODI is not utilized. The patient continues on TTD. Given these factors, this request is not medically necessary.

Urine toxicology: Overtaken

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing, Opioids Page(s): 43, 78, 94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug testing Page(s): 76-79.

Decision rationale: Regarding the request for a urine toxicology test, CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option in patients on controlled substances. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. There risk stratification is an important

component in assessing the necessity and frequency of urine drug testing. With the documentation available for review, there is documentation of prescription of controlled substances. Although no clear risk factor assessment, such as the utilization of the Opioid Risk Tool or SOAPP is apparent in the records, periodic urine drug testing is indicated. Although the tramadol is felt not be medically necessary at this juncture, the weaning process would require that the worker remain on this drug for some time. During this time, it is medically appropriate to continue random drug testing. Given this, this request is medically necessary.

Tramadol 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 78-80, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 75-80, 94.

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 the Federal Register the final rule placing tramadol into schedule IV of the Controlled Substances Act. This rule will become 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 primary treating physician 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. 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.