

Case Number:	CM15-0198132		
Date Assigned:	10/13/2015	Date of Injury:	11/08/2013
Decision Date:	11/20/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/08/2015

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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

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 52 year old male, who sustained an industrial injury on 11-8-13. The injured worker was diagnosed as having cervical strain and multilevel lumbar disc disease. The physical exam on 8-27-15 revealed 6 out of 10 pain in the cervical spine and low back , lumbar range of motion is 50% of expected and cervical range of motion is 75% of expected. As of the PR2 dated 10-1-15, the injured worker reports persistent low back pain and intermittent numbness and tingling of the lateral thighs, calves and feet. He rates his pain 6 out of 10. Objective findings include lumbar range of motion is 60% of expected and cervical range of motion is 75% of expected. Current medications include Voltaren gel (since at least 8-27-15) and Tramadol (since at least 8-27-15). Treatment to date has included an EMG-NCS (date of service and results not provided). The treating physician requested Tramadol 50mg #90, Voltaren gel 1% 200g and physical therapy x 8 sessions for the lower back. The Utilization Review dated 10-7- 15, non-certified the request for Tramadol 50mg #90, Voltaren gel 1% 200g and physical therapy x 8 sessions for the lower back.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50 mg Qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) - Medications for acute pain (analgesics), Tramadol (Ultram).

Decision rationale: Tramadol is classified as a central acting synthetic opioid. MTUS states regarding tramadol, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." ODG further states, "Tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/ acetaminophen." The treating physician did not provide sufficient documentation that the patient has failed a trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, no documentation was provided which discussed the setting of goals for the use of tramadol prior to the initiation of this medication. MTUS states "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, the request for tramadol 50mg #90 is not medically necessary.

Voltaren 1% gel, 200 g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: MTUS specifically states for Voltaren Gel 1% (diclofenac) that it is "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." Medical records do not indicate that the patient is being treated for osteoarthritis pain in the joints. Additionally, the records indicate that the treatment area would possibly be for lumbar and or cervical spine, areas that this medication is not indicated for. As such, the request for Voltaren gel is not medically necessary.

Physical therapy, low back, 8 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Medical records indicate at least 8 prior physical therapy visits, there is no indication provided in the available medical record as to these sessions constituting, there are also no indication of results, improvements, etc. For additional visits beyond guideline initial recommendations information on these earlier visits is required. As such, the request for Physical therapy, low back, 8 sessions is not medically necessary.