

Case Number:	CM15-0203610		
Date Assigned:	10/20/2015	Date of Injury:	07/27/2013
Decision Date:	12/01/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	10/16/2015

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: Montana, Oregon, Idaho

Certification(s)/Specialty: Orthopedic Surgery

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 56 year old female who sustained an industrial injury on 7-27-13. The medical records indicate that the injured worker is being treated for chronic pain syndrome, lumbar spine, secondary to severe degenerative disk disease, retrolisthesis of L1, L2, L3 , L4, severe left lumbar radiculopathy cervical spine and left upper extremity chronic pain syndrome consistent with cervical radiculopathy, secondary to cervical disk disease; constipation to opioid and non-opioid analgesics. She currently (8-17-15) complains of severe low back pain and bilateral leg pain, more left than right with severe numbness and weakness of the left lower extremity; neck and upper extremity pain with numbness and weakness, more left than right. Her pain level is typically 8-10 out of 10 without treatment and interferes with her ability to perform activities of daily living such as personal hygiene, getting in and out of bed, off of the toilet and out of a chair. With Fentanyl her pain level is 6-8 out of 10 and with tramadol 5-6 out of 10. With medication her activities of daily living improve and she is able to walk around the house, perform at least basic hygiene, light housework. Per the 8-17-15 note "the patients previous opioid risk assessment has determined that the patient is at low risk for opioid misuse or abuse. The patient has repeatedly signed updated opioid analgesic agreements. Prior random urinary drug screens have demonstrated compliance with her medications". On physical exam of the cervical spine there was moderate to severe tenderness on palpation, persistent sensory deficits along the left C5, C6 and C7; lumbosacral exam revealed restricted range of motion, moderate tenderness over the right side, severe tenderness over the left lumbar paravertebral and gluteal muscles, positive straight leg raise bilaterally, persistent sensory deficits over left L3, L4, L5 and

S1 dermatomes; weakness of bilateral lower extremities, more significant on the left and weakness of the left upper extremity. The injured worker has undergone x-ray of the lumbar spine (4-17-15) which was normal; MRI of the lumbar spine (7-10-15) showing mild to moderate disc degeneration of lumbar spine. Treatments to date include transcutaneous electrical nerve stimulator unit that drops her pain level to 5-6 out of 10; medications: Cymbalta, docusate, tramadol (since at least 2-19-15), Gabapentin (since at least 2-19-15) "drops her pain for hours at a time" per 8-17-15 note; Aspercreme, Dendracin, Promalaxin; physical therapy (2013) for lumbar spine. On 5-11-15 the treating provider requested restarting a trial of physical therapy 3 times a week for 4 weeks for upper and lower extremities, back and low back. With gentle massage lumbosacral stretching and core strengthening. The request for authorization dated 4-28-15 was for tramadol 50mg #120; Gabapentin 400mg #120. The request to include physical therapy was not present. On 9-9-15 Utilization Review non-certified the request for tramadol 50mg #120; Gabapentin 400mg #120; physical therapy 3 times a week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50 MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, long-term assessment, Opioids for chronic pain.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. According to the CA MTUS/Chronic Pain Medical Treatment Guidelines a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. 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. 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. Opioids may be continued if the patient has returned to work and the patient has improved functioning and pain. According to the ODG pain section a written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. The lowest possible dose should be prescribed to improve pain and function. Use of drug screening or inpatient treatment with issues of abuse,

addiction, or poor pain control is recommended. Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. The ODG (Pain / Opioids for chronic pain) states According to a major NIH systematic review, there is insufficient evidence to support the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms. In this case based on the documentation there is insufficient evidence to recommend the chronic use of opioids. There is no documentation of increased level of function, percentage of pain relief, duration of pain relief, or that the injured worker has returned to work. Therefore the criteria set forth in the guidelines have not been met and the request is not medically necessary.

Gabapentin 400 MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Per the CA MTUS Chronic Pain Treatment Guidelines page 18, Specific Anti-Epilepsy Drugs, Neurontin is indicated for diabetic painful neuropathy and postherpetic neuralgia and is considered first line treatment for neuropathic pain. A good response to the use of AEDs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the trigger for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. In this case, the exam note does not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore the request does not meet criteria set forth in the guidelines and therefore is not medically necessary.

PT 3x4 (Transportation to Follow-Up Appt to Be Handled by Adjuster): Upheld

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

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

Decision rationale: According to the CA MTUS/ ACOEM Chronic Pain Medical Treatment Guidelines page 9, therapy for chronic pain ranges from single modality approaches for the

straight-forward patient to comprehensive interdisciplinary care for the more challenging patient. Therapeutic components such as pharmacologic, interventional, psychological and physical have been found to be most effective when performed in an integrated manner. All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Typically, with increased function comes a perceived reduction in pain and increased perception of its control. This ultimately leads to an improvement in the patient's quality of life and a reduction of pains impact on society. Physical therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instructions. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Physical Medicine Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. In this case the request for physical therapy is requested to treat multiple conditions, including low back pain. The cited guidelines for the treatment of low back pain recommend no more than 10 visits. As this request exceeds the recommended number of visits, the request is not medically necessary.