

Case Number:	CM15-0206418		
Date Assigned:	10/23/2015	Date of Injury:	01/06/2014
Decision Date:	12/04/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	10/21/2015

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: Texas, Florida, California

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

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 45 year old female, who sustained an industrial injury on 1-6-14. The injured worker was diagnosed as having right knee chondromalacia patella and osteochondral lesion; internal derangement left knee; cervical spondylosis protrusion C4-5 with radiculopathy; low back pain with lower extremity symptoms; thoracic myofascial pain; headache-dizziness-vision changes of uncertain etiology. Treatment to date has included physical therapy; medications. Currently, the PR-2 notes dated 9-17-15 indicated per the provider's documentation, the injured worker complains of "right knee pain worsening 8 out of 10 scale; low back pain with left greater than right lower extremity symptoms 6 out of 10; upper extremity symptoms 6 out of 10; complains of increased headache; thoracic pain 5 out of 10 and left knee pain 5 out of 10." The provider notes that current medications regimen facilitates maintenance of activities of daily living such as her household duties, shopping for groceries, grooming, and cooking. She report difficulty adhering to recommended home exercise without medication. The provider documents that "Tramadol ER 150mg two daily facilitate average five point diminution in somatic pain and improved range of motion and greater tolerance to exercise and variety of activity with medications on board." Objective findings are noted as tenderness to the lumbar spine with lumbar range of motion percent of normal: flexion 60; sensitive 50; left and right lateral tilt 50, left rotation 40. Positive straight leg raise left for pain to foot and right for pain to distal calf at 45 degrees. Upper extremities neurologic evaluation "essentially unchanged". Tenderness noted at the thoracic spine with range of motion limited. Right knee tenderness diffusely with swelling and range of motion 0-100 degrees. There is a noted decreased in spasm

in the lumboparaspinal musculature. The treatment plan is requesting a MRI of the lumbar spine and a neurology consult for her headaches. He is also requesting an extension of time for the cervical epidural injection at C4-5 with interventional pain management consult. An epidural steroid injection was approved for C4-5 with pain management but was never performed due to the availability of a medical provider within the network. He is also requesting Tramadol ER 150mg two PO every day and notes this will facilitate the discontinuation of the "Immediate-Release (IR) opioid. Patient has been consuming IR opioid at times greater than 5 a day prior to opioid Tramadol ER at 300mg a day, which has enabled a discontinuation of the IR opioid drug." A PR-2 notes dated 5-7-15; 6-4- 15; 7-2-15 and 8-27-15 indicate Tramadol ER 150mg#60 to #30 were dispensed on these dates. A Request for Authorization is dated 10-21-15. A Utilization Review letter is dated 10-20-15 and non-certification for a Cervical Epidural injection at C4-5 with pain management and Tramadol 150mg, #60. A request for authorization has been received for Cervical Epidural injection at C4- 5 with pain management and Tramadol 150mg, #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural injection at C4-5 with pain management: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, new ESI guidance and Other Medical Treatment Guidelines American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

Decision rationale: The injury is from 2014. The current California web-based MTUS collection was reviewed in addressing this request. They do not specifically isolate the neck are for these injections. The ODG and other sources simply as of late do not support cervical ESI. Per the ODG:1. Recent evidence: ESIs should not be recommended in the cervical region, the FDA's Anesthetic and Analgesic Drug Products Advisory Committee concluded. Injecting a particulate steroid in the cervical region, especially using the transforaminal approach, increases the risk for sometimes serious and irreversible neurological adverse events, including stroke, paraplegia, spinal cord infarction, and even death. The FDA has never approved an injectable corticosteroid product administered via epidural injection, so this use, although common, is considered off- label. Injections into the cervical region, as opposed to the lumbar area, are relatively risky, and the risk for accidental injury in the arterial system is greater in this location. (FDA, 2015) 2. An AMA review suggested that ESIs are not recommended higher than the C6-7 level; no cervical interlaminar ESI should be undertaken at any segmental level without preprocedural review; & particulate steroids should not be used in therapeutic cervical transforaminal injections. (Benzon, 2015) 3. According to the American Academy of Neurology (AAN), ESIs do not improve function, lessen need for surgery, or provide long-term pain relief, and the routine use of ESIs is not recommended. They further said that there is in particular a paucity of evidence for the use of ESIs to treat radicular cervical pain. (AAN, 2015) Regarding the pain management consult, the ACOEM Guidelines, Chapter 7, Page 127, state that the

occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. This request for the consult fails to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. At present, this portion of the request is also not medically necessary.

Tramadol 150mg, #60: 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 for chronic pain.

Decision rationale: Objective, functional improvement out of the medicine regimen is not noted. Per the MTUS, Tramadol is an opiate analogue medication, not recommended as a first-line therapy. The MTUS based on Cochrane studies found very small pain improvements, and adverse events caused participants to discontinue the medicine. Most important, there are no long-term studies to allow it to be recommended for use past six months. A long-term use of is therefore not supported. The request is not medically necessary.