

<b>Case Number:</b>	CM15-0209808		
<b>Date Assigned:</b>	10/28/2015	<b>Date of Injury:</b>	03/25/2015
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	10/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/26/2015

### 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: 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:

This is a 43 year old female who sustained an industrial injury on 3-25-2015. A review of the medical records indicates that the injured worker is undergoing treatment for cervical and thoracic musculoligamentous sprain-strain; lumbosacral spine musculoligamentous sprain-strain with bilateral lower extremity radiculitis; right shoulder periscapular strain; right forearm-wrist flexor and extensor tenosynovitis; right elbow medial and lateral epicondylitis with cubital tunnel syndrome and right wrist carpal tunnel syndrome. According to the Doctor's First Report of Occupational Injury or Illness dated 8-17-2015, the injured worker complained of neck, mid and low back pain with stiffness. She complained of right shoulder pain and right elbow, forearm, wrist and hand pain along with numbness and tingling to the right hand and both feet. Per the treating physician (8-17-2015), the injured worker was temporarily totally disabled. Objective findings (8-17-2015) revealed tenderness to palpation over the cervical, thoracic and lumbar paravertebral musculature and also the upper trapezius muscles. Sensation to pinprick and light touch in the bilateral lower extremities was decreased in an S1 dermatomal distribution. Treatment has included physical therapy, acupuncture and medications. The physician noted that the injured worker reported benefit in terms of control of pain and muscle spasm with the application of electrical muscle stimulation at physical therapy. Ultram was prescribed on 8-17-2015. Previous medications include Acetaminophen and Etodolac. The request for authorization was dated 8-17-2015. The original Utilization Review (UR) (10-2-2015) modified a request for Ultram from #120 to #60. Utilization Review denied requests for electromyography (EMG)-

nerve conduction velocity (NCV) of the bilateral lower extremities and a home interferential unit.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Ultram 50mgm #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** Tramadol is a central acting synthetic opioid that exhibits opioid activity with a mechanism of action that inhibits the reuptake of serotonin and norepinephrine with side effects similar to traditional opioids. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. In this case, it is not clear that the injured worker has failed with non-opioid pain medications. Additionally, this request for 120 tablets does not allow for close monitoring of initial efficacy, potential side effects or aberrant behavior. The request for Ultram 50mgm #120 is determined to not be medically necessary.

**EMG/NCV bilateral lower extremities:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), electrodiagnostic testing.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter,/Nerve Conduction Studies (NCS) Section.

**Decision rationale:** Per the MTUS Guidelines, EMG may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The MTUS Guidelines do not specifically address nerve conduction studies of the lower extremities. Per the ODG, nerve conduction studies are not recommended because there is minimal justification of performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. In this case, there is no objective evidence of neurologic dysfunction. The request for EMG/NCV bilateral lower extremities is determined to not be medically necessary.

**Home IF unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

**Decision rationale:** The MTUS Guidelines do not recommend an interferential stimulator as an isolated treatment, however it may be useful for a subset of individuals that have not had success with pain medications. The evidence that an interferential stimulator is effective is not well supported in the literature, and studies that show benefit from use of the interferential stimulator are not well designed to clearly demonstrate cause and effect. The guidelines support the use of an interferential stimulator for a one month trial to determine if this treatment modality leads to increased functional improvement, less reported pain and medication reduction. The request is not for a one month trial however, and the unit is not recommended for use without the trial and document evidence of benefit. The request for home IF unit is determined to not be medically necessary.