

<b>Case Number:</b>	CM15-0020780		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	12/09/2014
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2015

### 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:

The injured worker is a 57 year old female, who sustained an industrial injury on December 9, 2014. The diagnoses have included cervical and lumbar spine musculoligamentous sprain/strain, facet degenerative changes, lower extremity radiculitis, shoulder sprain/strain with impingement and history of arthroscopy, elbow epicondylitis, wrist tendinitis, hand contusion and knee arthralgia. Comorbid conditions include obesity (BMI 32.5). A progress note dated December 31, 2014 provided the injured worker complains of neck, shoulder, back, hand and knee pain. Physical exam noted tenderness and decreased range of motion (ROM) in affected areas. Radiographic imaging confirmed diagnoses. On January 15, 2015 utilization review non-certified a request for one back pillow, Ultram ER 150mg, #30 and Cyclobenzaprine 7.5mg, #60 and modified a request for twelve (12) sessions of chiropractic manipulative therapy with modalities, myofascial release and exercise. The American College of Occupational and Environmental Medicine (ACOEM) and Official Disability Guidelines (ODG) were utilized in the determination. Application for independent medical review (IMR) is dated January 28, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Twelve (12) sessions of chiropractic manipulative therapy with modalities, myofascial release and exercise:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 173, 298-299. Decision based on Non-MTUS Citation ODG Chiropractic Guidelines, Neck and Upper Back (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Harrison DD, Siskin LA, Betz JW, editor(s). Best practices & practice guidelines. Arlington (VA): International Chiropractors Association (ICA); 2013 Nov 22. 856 p. [12,534 references]

**Decision rationale:** Multiple studies have shown that manipulation is an effective therapy in acute and chronic spinal conditions. However, its use in chronic conditions, as required by the MTUS guidelines, necessitates documentation of functional improvement, that is, improvement in activities of daily living or a reduction in work restrictions. It is important to note that many studies have shown that the longer a patient has pain the less likely therapy will be effective. The request for chiropractic treatment for this patient was initiated during the acute time period after the injuries occurred. The injuries were from a motor vehicle accident. The evidence-based guidelines developed by the International Chiropractors Association recommend a minimum of 31 treatments post MVA for the minimal injuries and up to 76 treatments for more severe injuries. The requested therapy and associated number of visits falls well within these guidelines. Medical necessity has been established.

**One back pillow:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment General Approaches; Clinical Topics-Low Back Complaints Page(s): 3, 6.

**Decision rationale:** Orthopedic pillows in general are designed to correct body positioning in bed or while lying/sitting on any other surface. It is designed to conform with orthopedic guidelines to ensure the right placement and support of one or more specific parts of the body and to provide safe and healthy rest. A Back (lumbar) pillow is a half-moon shaped pillow used at the lower back to comfort and relieve lower back (lumbar) pain and keep a correct sitting-down position. There are no evidence-based studies or guidelines that addresses effectiveness of this therapeutic modality. However, there is no indication from the documentation in the patient's medical records that she has worsening pain with sitting. At this point in the care of this patient medical necessity for use of this modality has been established.

**Prescription of Ultram ER 150mg, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 181, 308.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-9, Chronic Pain Treatment Guidelines Opioids Page(s): 60-1, 74-96.

**Decision rationale:** Tramadol is a narcotic pain reliever with mu-receptor opioid agonist activity and is used to treat moderate to severe pain. Tramadol ER is an extended release formulation of this medication. Appropriate dosing should not exceed 400 mg/day and it should be used with caution in any patient taking Selective Serotonin Reuptake Inhibitors (SSRI) as together they may cause a potentially fatal condition known as Serotonin Syndrome. There are no studies showing effective use of this medication for chronic pain that lasts greater than 3 months. However, the MTUS describes use of narcotics for control of chronic pain. Even though this is not considered a first line therapy, the chronic use of narcotics is a viable alternative when other therapeutic modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction, overdose or death. The pain guidelines in the MTUS directly address this issue and have criteria for the safe use of chronic opioids. The patient injured herself just one month prior to the request for use of tramadol. There has not been any trial of first-line medications. At this point in the care of this patient use of opioids is not indicated. Medical necessity for use of tramadol ER has not been established.

**Cyclobenzaprine 7.5mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, 308.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Muscle Relaxants; Cyclobenzaprine Page(s): 41-2, 63-66.

**Decision rationale:** Cyclobenzaprine (Flexeril) is classified as a sedating skeletal muscle relaxant. It is recommended to be used three times per day. This class of medications can be helpful in reducing pain and muscle tension thus increasing patient mobility. Muscle relaxants as a group, however, are recommended for short-term use only as their efficacy appears to diminish over time. In fact, studies have shown cyclobenzaprine's greatest effect is in the first 4 days of treatment after which use may actually hinder return to functional activities. Muscle relaxants are considered no more effective at pain control than non-steroidal anti-inflammatory medication (NSAIDs) and there is no study that shows combination therapy of NSAIDs with muscle relaxants has a demonstrable benefit. This patient has been on muscle relaxant therapy for over 1 month. There are no present symptoms of muscle spasms or indications that these medications have improved patient's mobility or ability to return to work. Medical necessity for continued use of muscle relaxants (as a class) or Flexeril (specifically) has not been established.