

<b>Case Number:</b>	CM15-0222085		
<b>Date Assigned:</b>	11/17/2015	<b>Date of Injury:</b>	05/20/2014
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2015

### 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: Physical Medicine & Rehabilitation

### 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 injured worker is a 46 year old female, who sustained an industrial injury on 05-28-2014. The injured worker was diagnosed as having cervical spine disc herniation C5-6 and lumbar disc herniation L5-S1. On medical records dated 04-30-2015, 07-23-2015 and 10-16-2015, the subjective complaints were noted as thoracic-lumbar spine, cervical spine and bilateral hands and left knee. Pain was rated 6 out of 10. Objective findings were noted as decreased motion, sensation and loss of strength to the lumbar spine. Global tenderness about both wrists and x-rays were noted of lumbar and thoracic spine revealed loss of lumbar lordosis. Pain radiated from lower back to left ankle anteriorly, as well as weakness along with numbness in left foot. Lumbar spine was noted to have tenderness and spasm, as well as positive straight leg raise. Treatment to date included physical therapy, trigger point injections to lumbar spine, heat and ice. Current medications were not listed on 04-30-2015, 07-23-2015 and 10-16-2015. The Utilization Review (UR) was dated 10-28-2015. A Request for Authorization was dated 10-22-2015. The UR submitted for this medical review indicated that the request for Retro Tramadol 50mg #40 prescribed on 10-15-2015, physical therapy 3 times a week for 4 weeks for lumbar spine and MRI of cervical spine was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of cervical spine: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The patient was injured on 05/20/14 and presents with thoraco-lumbar spine pain, cervical spine pain, bilateral hand pain, and left knee pain. The request is for a MRI of the cervical spine to further assess the pathology. The utilization review denial letter does not provide a rationale. The patient is diagnosed with cervical spine disc herniation C5-6 and lumbar disc herniation L5-S1. Treatment to date includes physical therapy, trigger point injections to lumbar spine, heat and ice. The patient had a prior x-ray of the cervical spine which revealed loss of cervical lordosis. However, review of the reports provided does not indicate if the patient had a prior MRI of the cervical spine. The RFA is dated 10/22/15 and the patient is to return to modified work on 10/16/15. Regarding MRI, the ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back, pages 177-178 under Special Studies and Diagnostic and Treatment Considerations states: Neck and upper back complaints, under special studies and diagnostic and treatment considerations: Physiologic evidence of tissue insult or neurologic dysfunction. It defines physiologic evidence as a form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. ACOEM further states that unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient imaging to warrant imaging studies if symptoms persist. ODG Guidelines, Neck and Upper Back (acute and chronic) Chapter, under Magnetic Resonance Imaging states: Not recommended except for indications listed below. Indications for imaging MRI: Chronic neck pain (equals after 3 months of conservative treatment), radiographs are normal, neurologic signs or symptoms present. Neck pain with radiculopathy of severe or progressive neurologic deficit. The 04/30/15 treatment report states that the patient has a reduced cervical spine range of motion and positive neurogenic compression tests. In this case, the patient has not had a prior MRI of the cervical spine and given the patient's continued neck pain, this request appears reasonable. The requested MRI of the cervical spine is medically necessary.

**Retro Tramadol 50 mg #40 prescribed on 10/15/2015: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** The patient was injured on 05/20/14 and presents with thoraco-lumbar spine pain, cervical spine pain, bilateral hand pain, and left knee pain. The retrospective request is for tramadol 50 mg #40 prescribed on 10/15/2015 to alleviate pain and discomfort. The utilization

review denial letter does not provide a rationale. The patient is diagnosed with cervical spine disc herniation C5-6 and lumbar disc herniation L5-S1. Treatment to date includes physical therapy, trigger point injections to lumbar spine, heat and ice. The RFA is dated 10/22/15 and the patient is to return to modified work on 10/16/15. MTUS, Criteria for Use of Opioids Section, pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS, Criteria For Use Of Opioids Section, page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS, Criteria for Use of Opioids Section, p77, states that "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS, Medications for Chronic Pain Section, page 60 states that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity." MTUS, Opioids For Chronic Pain Section, pages 80 and 81 states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long- term efficacy is unclear (>16 weeks), but also appears limited." MTUS , page113 regarding Tramadol (Ultram) states: Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. For more information and references, see Opioids. See also Opioids for neuropathic pain. On 07/23/15, the patient rated her pain as a 9/10. The 10/15/15 treatment report states that the patient rated her pain as a 6/10. In this case, none of the 4 A's are addressed as required by MTUS Guidelines. Although there are general pain scales provided, there are no before and after medication pain scales. There are no examples of ADLs which demonstrate medication efficacy nor are there any discussions provided on adverse behavior/side effects. No validated instruments are used either. There are no pain management issues discussed such as CURES report, pain contract, et cetera. No outcome measures are provided as required by MTUS Guidelines. There are no urine drug screens provided to see if the patient is compliant with her prescribed medications. The treating physician does not provide adequate documentation that is required by MTUS Guidelines for continued opiate use. The requested Tramadol is not medically necessary.

**Physical therapy 3 times a week for 4 weeks for lumbar spine:** 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:** The patient was injured on 05/20/14 and presents with thoraco-lumbar spine pain, cervical spine pain, bilateral hand pain, and left knee pain. The request is for physical therapy 3 times a week for 4 weeks for lumbar spine to maintain core strengthening and reconditioning exercises. The utilization review denial letter does not provide a rationale. The

patient is diagnosed with cervical spine disc herniation C5-6 and lumbar disc herniation L5-S1. Treatment to date includes physical therapy, trigger point injections to lumbar spine, heat and ice. The RFA is dated 10/22/15 and the patient is to return to modified work on 10/16/15. MTUS Guidelines, Physical Medicine, pages 98 and 99 have the following: Physical medicine: Recommended as an indicated below. Allow for fading of treatments frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. MTUS Guidelines pages 98 and 99 state that for myalgia, myositis, 9 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits are recommended. There is no indication of any recent surgery the patient may have had. The 06/18/15 treatment report states that the patient will continue with her physical therapy. The 07/28/15 physical therapy initial evaluation note does not indicate how many sessions the patient will have in total. There is no indication of how these sessions impacted the patient's pain and function or when these sessions occurred. There is no discussion regarding why the patient is unable to establish a home exercise program to manage his pain. Furthermore, the requested 12 sessions of therapy exceeds what is allowed by MTUS guidelines. The request is not medically necessary.