

Case Number:	CM14-0214019		
Date Assigned:	12/31/2014	Date of Injury:	10/14/2014
Decision Date:	02/25/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/22/2014

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 27 year old patient with date of injury of 10/14/2014. Medical records indicate the patient is undergoing treatment for cervicogenic headaches, right upper extremity radicular symptoms, right shoulder pain, bilateral lower extremity radicular symptoms, sleep disturbance, anxiety, depression, closed head trauma and tinnitus. Subjective complaints include cervical spine pain rated 8/10, right upper extremity radicular pain; lumbar spine pain rated 9/10, bilateral lower extremity radicular pain, right shoulder pain rated 7/10. Objective findings include antalgic gait with stiffness; cervical range of motion - flexion 8 degrees, extension 2, left lateral 10, right lateral 7, left rotation 16, right rotation 11; lumbar range of motion - flexion 5 degrees, extension 3, left lateral 7, right lateral 4; right shoulder range of motion - flexion 42 degrees, extension 7, abduction 21, adduction 13, internal rotation 20, external rotation 9. CT of cervical spine dated 10/14/2014 revealed no acute fracture or dislocation, minimal degenerative changes at C4-C5 and C5-C6. CT scan of the lumbar spine dated 10/14/2014 revealed no evidence of acute fracture or dislocation of the lumbar spine, lumbarization of the S1 vertebral body with a partially formed disc at the S1-S2 level. Treatment has consisted of chiropractic care, Naproxen, Tramadol and Soma. The utilization review determination was rendered on 11/26/2014 recommending non-certification of Functional capacity evaluation, Tramadol 50mg #60, Soma 150mg #30, Chiropractic sessions x 12 to the cervical and lumbar spine, home trial of Transcutaneous Electrical Nerve Stimulation (TENS) x 1 month and urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Evaluation: 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21-42.

Decision rationale: ACOEM guidelines state "Consider using a functional capacity evaluation when necessary to translate medical impairment into functional limitations and determine work capability". Additionally, "It may be necessary to obtain a more precise delineation of patient capabilities than is available from routine physical examination. Under some circumstances, this can best be done by ordering a functional capacity evaluation of the patient." Progress notes by the treating physicians states clearly outline what the patient's limitations are and make no indication that additional delineation of the patient's capabilities are necessary to determine return to work. ODG further specifies guidelines for functional capacity evaluations "Recommended prior to admission to a Work Hardening (WH) Program.", "An FCE is time-consuming and cannot be recommended as a routine evaluation.", "Consider an FCE if 1. Case management is hampered by complex issues such as: Prior unsuccessful RTW attempts conflicting medical reporting on precautions and/or fitness for modified job. Injuries that require detailed exploration of a worker's abilities. 2. Timing is appropriate: Close or at MMI/all key medical reports secured. Additional/secondary conditions clarified." The medical documents provided do not indicate that any of the above criteria were met. The treating physician has not provided documentation of unsuccessful return to work attempts or that the patient is close to maximum medical improvement. As such, the request for Functional Capacity Evaluation is not medically indicated.

Tramadol 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol, Ultram. Page(s): 74-96, 113 and 123. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) - Medications for acute pain (analgesics), Tramadol (Ultram)

Decision rationale: Ultram is the brand name version of Tramadol, which is classified as central acting synthetic opioids. MTUS states regarding Tramadol that "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." ODG further states, "Tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/

Acetaminophen." The treating physician did not provide sufficient documentation that the patient has failed a trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, no documentation was provided which discussed the setting of goals for the use of Tramadol prior to the initiation of this medication. The original utilization review recommended weaning and modified the request, which is appropriate. As such, the request for Tramadol 50mg #60 is not medically necessary.

Soma 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) and Muscle relaxants (for pain). Page(s): 29 and 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Soma (Carisoprodol)

Decision rationale: MTUS states regarding Carisoprodol, "Not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is Meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of Meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs." ODG States that Soma is "Not recommended. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. This medication is not indicated for long-term use. The treating physician has not provided documentation of failure of first line medications and guidelines do not recommend the use of this medication. Treating physician does not detail circumstances that would warrant extended usage. As such, the request for Soma 150mg #30 is not medically necessary.

Chiropractic sessions x 12 to the cervical and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Chiropractic care and Manipulation.

Decision rationale: MTUS guidelines do not specifically address cervical neck chiropractic therapy, but does discuss chiropractic therapy in general. MTUS states, "Recommended for chronic pain if caused by musculoskeletal conditions." MTUS additionally quantifies, "b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition.

Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities." ODG writes, "It would not be advisable to use beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated." Additionally, ODG details criteria for treatment: Regional Neck Pain: 9 visits over 8 weeks; Cervical Strain: Intensity & duration of care depend on severity of injury as indicated below, but not on causation. These guidelines apply to cervical strains, sprains, whiplash (WAD), acceleration/deceleration injuries, motor vehicle accidents (MVA), including auto, and other injuries whether at work or not. The primary criterion for continued treatment is patient response, as indicated below. Mild (grade I - Quebec Task Force grades): up to 6 visits over 2-3 weeks; moderate (grade II): Trial of 6 visits over 2-3 weeks; Moderate (grade II): With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, avoid chronicity; Severe (grade III): Trial of 10 visits over 4-6 weeks; Severe (grade III): With evidence of objective functional improvement, total of up to 25 visits over 6 months, avoid chronicity. Cervical Nerve Root Compression with Radiculopathy: Patient selection based on previous chiropractic success. Trial of 6 visits over 2-3 weeks with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity and gradually fade the patient into active self-directed care. Post Laminectomy Syndrome: 14-16 visits over 12 weeks: Medical records indicate that this patient has undergone chiropractic treatment. The most recent documents provided indicate that this patient no longer wishes to attend chiropractic therapy. The treating physician does not note any improved objective or subjective findings, which is necessary for ongoing therapy. Additionally, the requested number of therapy sessions is in excess of guideline recommendations. As such, the request for Chiropractic sessions x 12 to the cervical and lumbar spine is not medically necessary.

Home Trial of Transcutaneous Electrical Nerve Stimulation (TENS) x 1 month: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for the use of TENS.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy.. Decision based on Non-MTUS Citation 54, 114-116, 118-120

Decision rationale: ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists." MTUS further states regarding interferential units, "Not recommended as an isolated intervention" and details the criteria for selection: Pain is ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant

pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). "If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits." The medical documentation provided does not indicate that this patient has utilized conservative treatment. There are no indications that this patient is diagnosed with diabetic neuropathy, post-herpetic neuralgia, phantom limb pain, complex regional pain syndrome or spinal cord injury. As such, the request for home trial of Transcutaneous Electrical Nerve Stimulation (TENS) x 1 month is not medically necessary.

Urine Drug Screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opiates, steps to avoid misuse/addiction.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and Substance abuse. Page(s): 74-96;108-109. Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009), pg 32 Established Patients Using a Controlled Substance

Decision rationale: MTUS states that use of urine drug screening for illegal drugs should be considered before therapeutic trial of opioids are initiated. Additionally use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion) would indicate need for urine drug screening. There is insufficient documentation provided to suggest issues of abuse, addiction, or poor pain control by the treating physician. University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009) recommends for stable patients without red flags "twice yearly urine drug screening for all chronic non-malignant pain patients receiving opioids - once during January-June and another July-December". The treating physician has not indicated why a urine drug screen is necessary at this time and has provided no evidence of red flags. The request for Tramadol has been non-certified. As such, the request for Urine Drug Screen is not medically necessary.