

<b>Case Number:</b>	CM15-0171604		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	09/17/2007
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/31/2015

### 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:

The injured worker is a 51 year old male, who sustained an industrial injury on 9-17-2007. The injured worker was diagnosed as having cervical spondylosis and cervical disc herniation. He was status post ACDF (anterior cervical discectomy with fusion) C5-6, C6-7 (date unspecified). Magnetic resonance imaging of the cervical spine (10-2011) was documented to show severe left C7 foraminal stenosis, moderate degenerative changes at C5-6, with mild to moderate left C6 foraminal stenosis. X-rays (3-2012) "with anatomic placement of the instrumentation at C5 to C7". X-rays (6-2012) "probable fusion at C5 to C7 with cage subsidence at C6-7 as well as adjacent kyphosis at C4-5". Treatment to date has included diagnostics and medications. Currently (8-10-2015), the injured worker complains of neck issues and left arm pain. He also reported low back pain. The treating physician noted that he had not seen the injured worker for 2 years due to the injured worker just being released from prison the last week. His interim history documented "no new issues" and his physical exam was noted as "unchanged". He inquired about pain medicine and stated that he was given Percocet in prison. The treating physician did not feel comfortable prescribing Percocet at the present time and recommended Lyrica and Tramadol. A history of methamphetamine use was noted. His work status was permanent and stationary. Urine toxicology (8-10-2015) was positive only for Oxycodone-Oxymorphone. Multiple diagnostics of the cervical spine (2011 and 2012) were referenced. The treatment plan included updated x-rays and magnetic resonance imaging of the cervical spine and Tramadol 50mg #40, non-certified by Utilization Review on 8-19-2015.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Tramadol (Ultram Tablets) 50mg #40: 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, Opioids, criteria for use, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

**Decision rationale:** The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. It cites opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. There is no evidence presented of random drug testing results or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. Additionally, there is no demonstrated evidence of specific increased functional status derived from the continuing use of opioids in terms of decreased pharmacological dosing with persistent severe pain for this chronic 2007 P&S injury without acute flare, new injury, or progressive neurological deterioration. The Tramadol (Ultram Tablets) 50mg #40 is not medically necessary and appropriate.

### **MRI of the neck spine without dye: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back, Magnetic Resonance Imaging (MRI).

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

**Decision rationale:** Per Treatment Guidelines for the Neck and Upper Back Disorders, under Special Studies and Diagnostic and Treatment Considerations, states Criteria for ordering imaging studies include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may

be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports, including report from providers have not adequately demonstrated the indication for repeating the MRI of the Cervical spine nor identify any specific acute change or progressive deterioration in clinical findings to support this imaging study for this 2007 P&S injury. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The MRI of the neck spine without dye is not medically necessary and appropriate.