

Case Number:	CM15-0070523		
Date Assigned:	04/20/2015	Date of Injury:	04/03/2012
Decision Date:	06/30/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/14/2015

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 41 year old woman sustained an industrial injury on 4/3/2012. The mechanism of injury is not detailed. Evaluations include bilateral shoulder x-rays and electrodiagnostic studies of the bilateral upper extremities before and after surgery. Diagnoses include carpal tunnel with surgical repair, bilateral shoulder strain/sprain with signs of impingement, and cervical spine sprain/strain with pain in the upper back and chest. Treatment has included oral medications, physical therapy, home exercise program, injections, and surgical intervention. Physician notes dated 3/9/2015 show complaints of pain tot eh bilateral upper extremities, shoulders, chest, upper and lower back. Recommendations include acupuncture, chiropractic treatment, consultation with a psychologist for cognitive behavior therapy, bilateral shoulder MRI, Pamelor, and Tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pamelor 25mg,: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-15.

Decision rationale: Per the 03/09/15 report the requesting physician states that the patient presents with bilateral upper extremity pain with pain in the shoulders, neck, across the upper chest and upper back and down the back. She is s/p CTR right 08/22/12 and CTR left 08/07/13. The current request is for Pamelor/Nortriptyline, a tricyclic antidepressant. The 04/02/15 utilization review modified this request to 1 month supply. No quantity is request as presented above. The RFA is not included. The patient is not working. MTUS Guidelines, page 13-15, CHRONIC PAIN MEDICAL TREATMENT GUIDELINES: Antidepressants for chronic pain states: "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. (Saarto-Cochrane, 2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment." The treating physician states that this medication is prescribed at bedtime for chronic pain with the possible associated benefit of improved sleep. This medication is indicated as a first line treatment for the patient's neuropathic pain. However, the reports provided for review show this medication has been prescribed since at least 09/22/14, and the treater does not state whether or not this medication helps the patient. The MTUS guidelines on page 60 require that the physician record pain and function when medications are used for chronic pain. The request IS NOT medically necessary.

Tramadol: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: Per the 03/09/15 report the requesting physician, [REDACTED] states that the patient presents with bilateral upper extremity pain with pain in the shoulders, neck, across the upper chest and upper back and down the back. She is s/p CTR right 08/22/12 and CTR left 08/07/13. The current request is for TRAMADOL, an opioid analgesic. The 04/02/15 modified this request to #30. No quantity is requested as presented above. The RFA is not included. The patient is not working. MTUS Guidelines 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 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. The reports provided for review show the patient has been prescribed this medication since at least 12/01/14. The 12/01/14 report by [REDACTED] states that Tramadol is helpful to the patient's pain. However, The MTUS guidelines require much more thorough documentation of analgesia with before and after pain scales and

functional improvements with opioid usage. No specific ADLs are mentioned to show a significant change with use of this medication. Opiate management issues are not fully discussed. While the requesting physician states the patient has a signed pain contract there is no discussion of adverse behavior. No UDS's are documented or provided for review and there is no mention of CURES. Side effects of Tramadol are discussed. In this case, Analgesia, ADLs, and Adverse behavior are not sufficiently documented as required by the MTUS guidelines. The request IS NOT medically necessary.

Chiro, Multi Upper Extremities, 8 sessions: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: Per the 03/09/15 report the requesting physician, [REDACTED] states that the patient presents with bilateral upper extremity pain with pain in the shoulders, neck, across the upper chest and upper back and down the back. She is s/p CTR right 08/22/12 and CTR left 08/07/13. The current request is for CHIRO MULTI UPPER EXTREMITIES 8 SESSIONS. The 04/02/15 utilization review modified this request from #8 to #6. The RFA is not included. The patient is not working. MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. MTUS page 8 also requires that the treater monitor the treatment progress to determine appropriate course of treatments. For manual therapy, the MTUs guidelines on page 59 states, "Delphi recommendations in effect incorporate two trials, with a total of up to 12 trial visits with a re-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24)." The 03/09/15 report states the patient has received no prior chiropractic treatment for her injury and this request is for bilateral upper extremity and shoulder pain. Guidelines recommend chiropractic treatment for chronic pain for musculoskeletal conditions, and the requested 8 sessions are within what is allowed by the MTUS. The request IS medically necessary.

Referral to Psychologist for 8 sessions of CBT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cognitive Behavioral Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines behavioral interventions Page(s): 23-24.

Decision rationale: Per the 03/09/15 report the requesting physician, [REDACTED] states that the patient presents with bilateral upper extremity pain with pain in the shoulders, neck, across the upper chest and upper back and down the back. She is s/p CTR right 08/22/12 and CTR left

08/07/13. The current request is for REFERRAL TO PSYCHOLOGIST FOR 8 SESSIONS OF CBT. The RFA is not included. The patient is not working. The MTUS guidelines on page 23-24 discuss behavioral interventions. CBT is recommended with an initial trial of 3-4 psychotherapy visits over 2 weeks. With evidence of objective functional improvement total of up to 6-10 visits over 5-6 weeks (individual sessions). The MTUS further state, "Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ)." The 03/09/15 report states this request is to help the patient better manage chronic pain. In this case the reports document this patient's chronic pain and her failure to improve substantially after two years of conservative and surgical treatment. There is no evidence of prior CBT treatment for the patient. However, guidelines require screening for risk factors of delayed recovery included fear avoidance beliefs, and no documentation of fear avoidance is provided in the reports included for review. Furthermore, the MTUS allow an initial trial of 3-4 visits and this request is for 8 visits. The request IS NOT medically necessary.