

Case Number:	CM15-0093004		
Date Assigned:	05/19/2015	Date of Injury:	10/17/2014
Decision Date:	09/22/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/14/2015

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: Emergency 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 40 year old female, who sustained an industrial injury on 10/17/14. She has reported initial complaints of using excessive force to operate a manual pallet jack and noted low back pain. The diagnoses have included lumbar spine strain/sprain, discogenic back pain, lumbago, lumbosacral radiculitis, and lumbar spine chronic myofascitis. Treatment to date has included medications, rest, activity modifications, heat, diagnostics, physical therapy and home exercise program (HEP). Currently, as per the physician progress note dated 4/10/15, the injured worker complains of constant pain in the right shoulder, lower back pain with numbness and tingling in the bilateral legs and intermittent pain in the hips that is aching and stiff. She reports that the shoulder pain and hip pain is unchanged but the low back pain is worsening. She also reports difficulty sleeping due to pain, decreased muscle mass, and numbness with pain and tingling. Physical exam of the lumbar spine reveals extradural involvement/sciatic tension is positive bilaterally, there is tenderness to palpation in the lumbar area bilaterally, right greater than left and there is decreased range of motion bilaterally due to pain. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine dated 2/19/15 that reveals lumbar spondylosis, disc protrusion, narrowing of the neural foramen, and posterior osteophyte disc complex. The current medications included Ultram, Flexeril, and analgesic topical creams. The previous physical therapy sessions were noted in the records. There was no urine drug testing noted in the records. Work status is temporary total disability until 5/20/15. The physician requested treatments included Tramadol ER #90 with 1 refill, Flexeril 10mg #90, Analgesic topical creams, Baseline functional capacity evaluation (FCE),

Range of motion testing, Acupuncture 2 x a week for 6 weeks and Chiropractic treatment 2 x a week for 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Tramadol (Ultram) Page(s): 77-80, 93-94, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 (pages 80-83 of 127) Page(s): 8 C.C.R. 9792.20-9792.26 (pages 80-83 of 127).

Decision rationale: Tramadol is a pain medication in the category of a centrally acting analgesic. They exhibit opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Centrally acting drugs are reported to be effective in managing neuropathic type pain although it is not recommended as first line therapy. The side effect profile is similar to opioids. For chronic back pain, it appears to be efficacious for short term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. The use of tramadol for osteoarthritis is indicated for short term use only (<3 months) with poor long-term benefit. In this case, the patient does not meet the qualifying criteria or indications. As such, the request is not certified and therefore is not medically necessary.

Flexeril 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 (pages 63 of 127) Page(s): 8 C.C.R. 9792.20-9792.26 (pages 63 of 127).

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate qualifying evidence for use of a muscle relaxant, the request is not certified. All muscle relaxant medications should be titrated down slowly to prevent an acute withdrawal syndrome and therefore is not medically necessary.

Analgesic topical creams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 (pages 111 to 113 of 127) Page(s): 8 C.C.R. 9792.20-9792.26 (pages 111 to 113 of 127).

Decision rationale: The request is for the use of a medication for topical use to aid in pain relief. These products sometimes contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended". In this case, the request is not specified with regards to what topical agent is to be used. As such, the request is not certified and therefore is not medically necessary.

Baseline functional capacity evaluation (FCE): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition, 2004, Chapter 7, Independent Medical Examinations and Consultations, pg. 132-139.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional capacity evaluation.

Decision rationale: The request is for a functional capacity evaluation. The MTUS guidelines are silent regarding this issue. The ODG state the following: Guidelines for performing an FCE: Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. 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. Do not proceed with an FCE if; the sole purpose is to determine a worker's effort or compliance; The worker has returned to work and an ergonomic assessment has not been arranged. (WSIB, 2003) In this case a functional capacity evaluation is not indicated. There is inadequate documentation of the patient and employer actively participating in determining the suitability of a particular job. As such, the request is not certified and therefore is not medically necessary.

Range of motion testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.ncbi.nlm.nih.gov/pubmed/16571400.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Flexibility.

Decision rationale: The request is for range of motion testing. The MTUS guidelines are silent regarding this issue. The ODG state the following: Not recommended as primary criteria but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. This has implications for clinical practice as it relates to disability determination for patients with chronic low back pain, and perhaps for the current impairment guidelines of the American Medical Association. (Parks, 2003) (Airaksinen, 2006) The value of the sit-and-reach test as an indicator of previous back discomfort is questionable. (Grenier, 2003) The AMA Guides to the Evaluation of Permanent Impairment, 5th edition, state, "an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way" (p 400). They do not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. (Andersson, 2000) Measurement of three dimensional real time lumbar spine motion including derivatives of velocity and acceleration has greater utility in detecting patients with low back disorder than range of motion. (Cherniack, 2001) See also Stretching. In this case, range of motion testing is not indicated. This is secondary to poor evidence of therapeutic value. As such, the request is not certified and therefore is not medically necessary.

Acupuncture 2 x a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The request is for acupuncture to aid in pain relief. The ACOEM guidelines state the following regarding this topic. "Acupuncture has not been found effective in the management of back pain, based on several high-quality studies, but there is anecdotal evidence of its success". In this case the guidelines do not support the use of this treatment modality. This is secondary to the diagnosis with poor clinical evidence regarding efficacy. As such, the request is not certified and therefore is not medically necessary.

Chiropractic treatment 2 x a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 (pages 58-60 of 127) Page(s): 8 C.C.R. 9792.20-9792.26 (pages 58-60 of 127).

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not certified and therefore is not medically necessary.