

Case Number:	CM13-0029373		
Date Assigned:	11/01/2013	Date of Injury:	04/13/1993
Decision Date:	12/09/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	09/26/2013

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. The expert reviewer is Board Certified in Emergency Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient had a reported date of injury on 4/13/1993. No mechanism of injury was documented. Diagnosis written down was cervical herniated nucleus pulposus and lumbar herniated nucleus pulposus. The medical reports were reviewed and the last report available was until 8/30/13. Many of the progress notes are hand written and are limited by very poor legibility and minimal documentation. The patient complains of "some relief" with cervical injection, has continued low back and thoracic pain. The objective exam reveals Spurling's, spasms and tenderness and there is decreased range of motion. The lumbar exam reveals straight leg raise, decreased Range of Motion (ROM), spasms and tenderness. The cervical x-ray was scribbled down as "cervical scoliosis". There was no date of study was documented. There was no rationale for services documented. They just wrote down "authorization for cervical spine", "Continue meds, celexa, percocet" The last legible note is a referral letter dated 8/20/13. It notes that the patient has a diagnosis of cervical foraminal stenosis and has a C6-7 anterior cervical discectomy and fusion in 7/1994. The patient also had a T7-(not readable) fusion in 2007 and mostly complains of neck pain. The medication listed on that letter include Percocet, lisinopril, HCTZ, Baclofen and Metformin. The letter notes the last MRI of Cervical spine was from 11/13/2011 which showed solid fusion and multilevel foraminal stenosis. It notes that a CT Scan of the cervical spine was to determine "how his bony anatomy is and what we can do with that in the future". The Independent Medical Review request is for a CT Scan of Cervical Spine and "percocet". The Prior Utilization Review (UR) on 9/13/2013 recommended denial.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan of the cervical spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- CT

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: As per ACOEM guidelines, indications for neck imaging include "red flag" findings, physiological evidence of neurological or physiological dysfunction, failure to progress in strengthening program and pre-invasive procedure. The documentation does not support any indication for imaging. Injury occurred over 20years prior. There is no documentation of prior conservative care. There is no documentation of worsening symptoms but actual improvement after cervical injection. The neurological exam was not documented. The reasoning for a CT scan was to determine, "how his bony anatomy is and what we can do with that in the future" is not a valid reason for CT scanning. The CT Scan of cervical spine is not medically necessary.

Percocet: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78.

Decision rationale: Percocet is an Acetaminophen and Oxycodone is an opioid. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. The documentation fails all criteria. There is no documented pain scale, improvement in pain or function with medications or proper monitoring documented by the provider. The prescription (scan provided for review) is illegible. The dosage and number of tablets requested cannot be determined due to poor hand writing. "Percocet" is not medically necessary and appropriate.