

<b>Case Number:</b>	CM13-0036393		
<b>Date Assigned:</b>	01/10/2014	<b>Date of Injury:</b>	08/31/1998
<b>Decision Date:</b>	03/24/2014	<b>UR Denial Date:</b>	10/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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:

This is a 51-year-old male who sustained injury on 08/31/1998 due to repetitive work activities to his neck, back, and shoulders. Treatment history included several medications, physical therapy, cervical and lumbar injections including cervical ESIs, lumbar facet injections, lumbar radiofrequency ablation, cervical spinal cord stimulator. Past surgical history includes anterior C5-6 and C6-7 decompression, discectomy, and fusion in 2000 and posterior posterior C5-6 and C6-7 fusion in 2002. He also had urine drug screenings. Cervical MRI dated 02/14/2011 showed status post fusion of C5 through C7 with multilevel degenerative changes, C4-5 disc bulge with mild central spinal stenosis, C5-6 and C6-7 status post fusion without spinal stenosis and worsened foraminal stenosis. EMG/NCS of upper extremities dated 11/15/2011 showed axonal sensory neuropathy of the left ulnar sensory nerve and no evidence of cervical radiculopathy. A clinic note dated 09/03/2013 indicates he presented with chief complaints of neck, shoulder and mid-low back pain. Medication list included Amitriptyline, Duragesic, Percocet, MS Contin, Ambien, Cholesterol/HTN medications, Prilosec, Proac, Neurontin, and Wellbutrin. On physical exam, no assistive device utilized. Stable gait with normal cadence, stride and posture. Tenderness to palpation over bilateral cervical paraspinals. No instability. Cervical ROM flexion 10, Extension 0, Left lateral Bending 0, Right lateral bending 0, Left Rotation 20, and Right Rotation 20. Bilateral upper extremities ROM normal. Motor strength left deltoid, biceps, and wrist extensor 4/5; left triceps, grip and interosseous 3/5. Right upper extremity strength was 5/5. Sensation was decreased in left C6 dermatome. DTRs 1+ and symmetric in bilateral UE. ██████ unable to perform due to lack of ROM. Negative Hoffmann. He was diagnosed with chronic pain syndrome, chronic postoperative pain, cervicgia, cervical radiculitis, cervical postlaminectomy syndrome, cervical stenosis, cervical disc degeneration, headaches, shoulder pain, paresthesia, and insomnia. Plan was continue medications MS Contin,

Percocet, Duragesic, Amitriptyline, Ambien CR, Lidoderm patch, Celebrex; random urine toxicology screening panel; pt for cervical spine, bilateral shoulder and lumbar spine; CT of the lumbar spine to rule out stenosis and evaluate for any change from prior scans; and electronic analysis of implanted complex spinal cord or peripheral neurostimulator pulse generator with programming.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Percocet 10/325mg, #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-82.

**Decision rationale:** As per CA MTUS chronic pain medical treatment guidelines, continued use of opioids is recommended if there is "ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects." In this case, the provider consistently documented throughout for at least since February 2013 that "medications only make it slightly better. The medications have lost effectiveness." There is no documentation that the patient has improved functioning and pain with the use of this medication or returned to work. Thus, the request for Percocet 10/325 mg #120 is not medically necessary and is non-certified. Furthermore, the guidelines recommend slow tapering/weaning process due to the risk of withdrawal symptoms.

**MS Contin 60mg, #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-82.

**Decision rationale:** MS Contin (morphine sulfate extended-release) is controlled, extended and sustained release preparations should be reserved for patients with chronic moderate to severe pain. As per CA MTUS chronic pain medical treatment guidelines, continued use of opioids is recommended if there is "ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects." In this case, the provider consistently documented throughout for at least since February 2013 that "medications only make it slightly better. The medications have lost effectiveness." There is no documentation that the patient has improved functioning and pain with the use of this medication or returned to work. Thus, the request for MS Contin 60 mg #90 is not medically necessary and is non-certified. Furthermore, the guidelines recommend slow tapering/weaning process due to the risk of withdrawal symptoms.

**Physical therapy to cervical spine and bilateral shoulders QTY: 18:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** As per CA MTUS chronic pain medical treatment guidelines, physical medicine is recommended to help control swelling, pain and inflammation during the rehabilitation process. The guidelines recommend total number of visits allowed for myalgia and myositis is 9-10 visits and for neuralgia, neuritis and radiculitis is 8-10 visits with documentation of objective functional improvement. Furthermore guidelines recommend that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The request for physical therapy to cervical spine and bilateral shoulders x18 sessions exceeds the guidelines recommendation. Also, records indicate that he was previously partially certified 6 sessions of physical therapy, but it is unclear if he ever completed the certified sessions. If yes, then these treatments resulted in any functional improvement. Thus, the request is non-certified

**Ambien 12.5mg, #30:**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG - Chapter - Pain (Chronic), Zolpidem (Ambien).

**Decision rationale:** CA MTUS chronic pain medical treatment guidelines do not discuss the requested treatment, thus ODG have been consulted. As per ODG, Zolpidem (Ambien) is recommended for short-term (2-6 weeks) to treat insomnia secondary to chronic pain. The long-term use is not recommended due to risk of addiction and may impair function and memory. This patient is on this medication for prolonged period of time and thus the request is non-certified.

**CT scan of the lumbar spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** CA MTUS guidelines recommend CT scan if unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. Review of records do not reveal documentation of objective neurological deficits

including diminished lower extremities reflexes, sensory or motor deficits in lower extremities, or positive SLR. Thus, the request for CT scan of the lumbar spine is non-certified.