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| Case Number: | CM13-0037500 | | |
| Date Assigned: | 12/13/2013 | Date of Injury: | 02/26/2010 |
| Decision Date: | 03/18/2014 | UR Denial Date: | 10/15/2013 |
| Priority: | Standard | Application Received: | 10/23/2013 |

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 Internal Medicine, has a subspecialty in Rheumatology and is licensed to practice in Maryland. 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 patient is a 52 year old male with date of injury 2/26/10. The mechanism of injury is described as an injury to the neck while lifting heavy boxes. The patient has complained of head, shoulder, bilateral arm and neck pain. Treatment thus far has included an anterior cervical fusion and discoplasty (02/2012), chiropractic therapy, physical therapy, TENS unit, acupuncture, epidural corticosteroid injections and medications. MRI of the thoracic spine dated 08/2012 showed degenerative joint disease at T5-T6. CT of the cervical spine dated 08/2012 showed anterior fusion of C4-C7 and neuroforaminal narrowing. Objective: decreased range of motion of the back in all planes. Diagnoses: post laminectomy syndrome cervical spine, brachial neuritis. Treatment plan and request: Fentanyl patch, oxycodone, promethazine, Zofran, peri-dolce, ultracin lotion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 25mg/hr patch: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78-79,84-85,93.

Decision rationale: This patient is a 52 year old male with head, shoulder, bilateral arm and neck pain since date of injury 2/26/10. Treatment has included anterior cervical fusion and discolasty (02/2012), chiropractic therapy, physical therapy, TENS unit, acupuncture, epidural corticosteroid injections and medications, to include a fentanyl patch since at least 01/2013. There are no adequate physician provider notes that address the specific indications for ongoing use of opioids in this patient as well as assess the patient with respect to function, specific benefit, return to work, signs of abuse and discussion of treatment alternatives other than opioids. There is no documentation of specific functional benefit or adequate monitoring during the documented office visits. With this lack of documentation and per the MTUS guidelines cited above Fentanyl patch 25 mcg is not indicated as medically necessary.

Oxycodone 10 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78-79, 84-85, 93.

Decision rationale: This patient is a 52 year old male with head, shoulder, bilateral arm and neck pain since date of injury 2/26/10. Treatment has included anterior cervical fusion and discoplasty (02/2012), chiropractic therapy, physical therapy, TENS unit, acupuncture, epidural corticosteroid injections and medications, to include oxycodone since at least 01/2013. There are no adequate physician provider notes that address the specific indications for ongoing use of opioids in this patient as well as assess the patient with respect to function, specific benefit, return to work, signs of abuse and discussion of treatment alternatives other than opioids. There is no documentation of specific functional benefit or adequate monitoring during the documented office visits. With this lack of documentation and per the MTUS guidelines cited above, Oxycodone is not indicated as medically necessary.

Promethazine 25 mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: This patient is a 52 year old male with head, shoulder, bilateral arm and neck pain since date of injury 2/26/10. Treatment has included anterior cervical fusion and discoplasty (02/2012), chiropractic therapy, physical therapy, TENS unit, acupuncture, epidural corticosteroid injections and medications. Promethazine, an anti-nausea medication is not indicated as medically necessary due to the lack of provider documentation of rationale for use of this medication. There is no documentation of ongoing nausea as an active medical issue.

Zofran 8 mg #39 with one refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: This patient is a 52 year old male with head, shoulder, bilateral arm and neck pain since date of injury 2/26/10. Treatment has included anterior cervical fusion and discolplasty (02/2012), chiropractic therapy, physical therapy, TENS unit, acupuncture, epidural corticosteroid injections and medications. Zofran is a medication used to treat nausea and/or vomiting due to surgical procedures or treatment for cancer (chemotherapy or radiation). There is no documentation in the available medical records that a recent surgery has been performed or that cancer treatment has been provided. On the basis of this lack of medical findings, Zofran is not indicated as medically necessary.

Peri-dolce 8.6-50mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: This patient is a 52 year old male with head, shoulder, bilateral arm and neck pain since date of injury 2/26/10. Treatment has included anterior cervical fusion and discoplasty (02/2012), chiropractic therapy, physical therapy, TENS unit, acupuncture, epidural corticosteroid injections and medications. Peri-dolce 8.6, a treatment for constipation, is not indicated as medically necessary due to the lack of documentation in the available medical records that constipation is a symptom or medical problem in this patient.

Ultracin lotion with 11 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topicals Page(s): 28-29, 105.

Decision rationale: This patient is a 52 year old male with head, shoulder, bilateral arm and neck pain since date of injury 2/26/10. Treatment has included anterior cervical fusion and discoplasty (02/2012), chiropractic therapy, physical therapy, TENS unit, acupuncture, epidural corticosteroid injections and medications. Per the MTUS guidelines cited above, topical agents in the treatment of chronic pain are largely experimental and recommended for the treatment of neuropathic pain only when trials of either an anticonvulsant or antidepressant medication have failed. There is no such documentation provided in the available medical records. Per the MTUS guidelines above, Ultracin lotion is not indicated as medically necessary.