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| Case Number: | CM13-0056298 | | |
| Date Assigned: | 01/24/2014 | Date of Injury: | 08/31/1998 |
| Decision Date: | 06/12/2014 | UR Denial Date: | 11/19/2013 |
| Priority: | Standard | Application Received: | 11/22/2013 |

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 Orthopedic Surgery, 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 is a 51 year old male who sustained an injury on 08/31/98. The patient sustained multiple injuries to the body on the date of injury. His diagnoses include cervical spine sprain/strain, right shoulder impingement, right shoulder cartilage damage, radiculopathy, subacromial/subdeltoid bursitis, lumbar spine sprain/strain, right bicipital tendonitis, and lumbosacral radiculopathy. He received prior radiofrequency ablation procedures in the lumbar spine and multiple epidural steroid injections. He is s/p cervical fusion at C5-6 and C6-7 in April of 2000. The patient also received a spinal cord stimulator implant in 07/13. The clinical record from [REDACTED] on 09/03/13 noted the patient was continuing to have some benefit from the spinal cord stimulator in conjunction with medications; however, the patient continued to indicate that his medications had lost effectiveness. On physical examination there was continued loss of cervical range of motion with mild to moderate weakness in the upper extremities left side worse than right. There was continued decreased sensation in a left C6 dermatomal distribution. Reflexes were 1+ and symmetric in the upper extremities. Hoffman sign was negative. Lumbar spine demonstrated flexion 10 degrees/90 degrees. Extension 0 degrees/25 degrees. Bilateral lateral flexion 5 degrees/25 degrees. Unable to toe heel walks; all motions caused severe muscle spasm. Examination of the right shoulder revealed a positive Neer's/90 degrees cross over. Medications at this visit included MS Contin 60mg three times daily, Percocet 10mg four times daily, Duragesic 25mcg per hour patch changed every 72 hours, Amitriptyline 50mg, Ambien 12.5mg, Lidoderm patches utilized ever 12 hours off and on, and Celebrex 200mg everyday as needed. Urine drug screen testing was ordered in September of 2013. Follow-up with [REDACTED] on 10/01/13 reported some benefit from spinal cord stimulation. Physical examination findings remained unchanged. The treating provider has requested urine drug screen (performed

10/1/13), Physical therapy for bilateral shoulders, cervical spine, lumbar spine 18 sessions, CT scan of the lumbar spine, MS Contin 60mg #90, Percocet 10mg # 120, and Ambien 12.5 # 30.

IMR ISSUES, DECISIONS AND RATIONALES

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

URINE DRUG SCREEN (PERFORMED 10/1/13): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Testing Page(s): 43.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Urine Drug Screens.

Decision rationale: In regards to the requested urine drug screen on 10/01/13, the clinical documentation submitted for review would not have supported medical necessity for this testing. Urine drug screens were requested in September of 2013 and the subsequent documentation from [REDACTED] did not identify the results from this previous testing. There was no other indication from the clinical record that the patient was suspected of any high risk factors for opiate abuse that would warrant repeat urine drug screen screens one month after prior screens had been obtained. Medical necessity for the requested item was not established. The requested Urine Drug Screen was not medically necessary.

PHYSICAL THERAPY FOR THE CERVICAL SPINE, BILATERAL SHOULDERS AND LUMBAR SPINE, QTY: 18.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine and Functional improvement measures, Definitions.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 97-98.

Decision rationale: In regards to the request for physical therapy for the cervical spine, bilateral shoulders, and lumbar spine; the previous request was modified for six sessions only. The clinical documentation submitted for review noted multiple functional limitations in the shoulders, cervical spine, and lumbar spine. However, there were no exceptional factors on physical examination that supported more than the initial six sessions of physical therapy allowed for the patient. Medical necessity for the requested item was not established. The requested Physical Therapy for the Cervical Spine was not medically necessary.

CT SCAN OF LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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

Decision rationale: The requested CT scan of the lumbar spine was not medically necessary and indicated for the evaluation of the claimant's condition. The claimant did not present with any clear progressive or severe neurological deficits or other red flags to support CT studies of the lumbar spine. There was also no indication of any contraindication for standard MRI. Also no updated radiographic studies of the lumbar spine were completed prior to the imaging request. Medical necessity for the requested item was not established. The requested item was not medically necessary.

PRESCRIPTION OF MS CONTIN 60MG, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 88-89.

Decision rationale: In regards to the prescription for MS Contin 60mg quantity 90, the previous utilization review recommended modification for 60 tablets only to facilitate weaning. There was no indication from the clinical records substantiating the 90 tablets requested for this medication. Records indicated the patient felt limited improvement was being obtained with narcotic medications. The patient stated that medications had lost effectiveness. There was also a permanent spinal cord stimulator implanted that was providing benefit. Per guidelines, the patient would be recommended to slowly wean off of narcotics due to lack of efficacy and the benefit obtained from spinal cord stimulator. Medical necessity for the requested item was not established. The requested item was not medically necessary.

PRESCRIPTION OF PERCOCET 10MG, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain, Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 88-89.

Decision rationale: In regards to the prescription for Percocet 10mg quantity 120, the previous utilization review recommended modification for 90 tablets only to facilitate weaning. There was no indication from the clinical records substantiating the 120 tablets requested for this medication. Records indicated the patient felt limited improvement was being obtained with narcotic medications. The patient stated that medications had lost effectiveness. There was also a permanent spinal cord stimulator implanted that was providing benefit. Per guidelines, the patient would be recommended to slowly wean off of narcotics due to lack of efficacy and the benefit obtained from spinal cord stimulator. Medical necessity for the requested item was not established. The requested item was not medically necessary.

PRESCRIPTION OF AMBIEN 12.5MG, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment In Worker's Comp 2012 on the Web (www.odgtreatment.com), Zolpidem (Ambien).

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

Decision rationale: In regards to the use of Ambien 12.5mg quantity 30, The use of Ambien to address insomnia is recommended for a short term duration no more than 6 weeks per current evidence based guidelines. Furthermore, the FDA has recommended that dosing of Ambien be reduced from 12.5mg to 6.25mg due to adverse effects. The clinical documentation submitted for review does not provide any indications that the use of Ambien was effective in improving the claimant's overall functional condition. Medical necessity for the requested item was not established. The requested Ambien, 12.5mg was not medically necessary.