

Case Number:	CM14-0094358		
Date Assigned:	07/25/2014	Date of Injury:	09/09/2010
Decision Date:	09/09/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/23/2014

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 Anesthesiology, has a subspecialty in Pain Management, 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:

According to the records made available for review, this is a 51-year-old male with a 9/9/10 date of injury, and status post cervical fusion C6-7 as of 2011. At the time of the request for authorization, there is documentation of constant neck pain that radiates to the right shoulder and arm rated 8/10, increased neck pain since last MRI done six months ago, being unable to completed activities of daily living due to pain, antalgic gait, paravertebral muscle tenderness, spinous process tenderness, power grip 3/5 on the left, 3/5 muscle strength right finger extensors, shoulder external rotation 1/5, shoulder internal rotation 2/5, right shoulder flexion and abduction 45 degrees. An MRI of the cervical spine taken on 10/14/13 revealed status post anterior cervical fusion at C6-7; C2-3 left and right paracentral herniated disc, superimposed disc bulge, bilateral foraminal stenosis; C3-4 broad-based herniated disc, bilateral foraminal stenosis; C4-5 herniated disc in contact with the cord, superimposed disc bulge, moderate bilateral foraminal stenosis; C5-6 annular tear with central herniated disc in contact with the cord, superimposed bulge, severe bilateral foraminal stenosis; and C6-7 disc bulge, bilateral foraminal narrowing. Current diagnoses include cervical disc displacement and right shoulder pain, and treatment to date has been physical therapy, activity modification, and medications, including Norco and Fentanyl. A 4/18/14 medical report identifies that medications are effective in temporarily reducing the pain level. In addition, the 4/18/14 medical report identifies that due to patient's recent increase in pain and daily neck spasms an MRI is important to check for new injuries and disease progression.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI C/S without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines - Neck & Upper Back: Magnetic Resonance Imaging (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

Decision rationale: The MTUS/ACOEM guidelines state that an MRI may be recommended with documentation of red flag diagnoses where plain film radiographs are negative, physiologic evidence (in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans) of tissue insult or neurologic dysfunction, failure of conservative treatment; or diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. The Official Disability Guidelines state that a repeat MRI may be recommended with documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary. Within the medical information available for review, there is documentation of diagnoses of cervical disc displacement and right shoulder pain. However, despite documentation of increase in pain and daily neck spasms, there is no documentation of a diagnosis/condition for which a repeat study is indicated. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.

Acupuncture 8 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The MTUS Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery, to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. In addition, the Acupuncture Medical Treatment Guidelines allow the use of acupuncture for musculoskeletal conditions. The time to produce functional improvement is 3-6 treatments, at a frequency of 1-3 times per week, and a duration of 1-2 months. Within the medical information available for review, there is documentation of diagnoses of cervical disc

displacement and right shoulder pain. In addition, there is documentation of functional deficits and functional goals. However, given that the request is for acupuncture 8 sessions, the proposed number of sessions exceeds guidelines for an initial trial. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.

Fentanyl patch 50mcg #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Duragesic and Fentanyl, and the FDA guidelines.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means, as criteria necessary to support the medical necessity of Fentanyl transdermal system. Guidelines state that Duragesic is not recommended as first-line therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications or medical services. The Official Disability Guidelines state that Duragesic is not for use in routine musculoskeletal pain. The FDA states that Fentanyl may be recommended with documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic 25 mcg/h; and no contraindications exist. Within the medical information available for review, there is documentation of diagnoses of cervical disc displacement and right shoulder pain. In addition, there is documentation of moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time and that the patient is already receiving opioid therapy. However, there is no documentation that pain cannot be managed by other means; that the patient has demonstrated opioid tolerance, and that no contraindications exist. In addition, despite documentation that medications are effective in temporarily reducing the pain level, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of Fentanyl patch use to date. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.