

Case Number:	CM14-0101348		
Date Assigned:	07/30/2014	Date of Injury:	10/21/2003
Decision Date:	12/04/2015	UR Denial Date:	06/24/2014
Priority:	Standard	Application Received:	07/01/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 injured worker is a 55 year old male who sustained an industrial injury on 10-21-2003. The worker on the exam of 04-21-2014 is seen by a pain management specialist for evaluation of chronic neck pain related to a work injury. Treatments for his work injury have included a 3 level anterior fusion C4-C7 (2004), in 2006 he had a posterior cervical decompression and in 2006 a revision anterior-posterior surgery. In 2010, he had colon cancer, went through chemo, and developed neuropathy in hands and feet from the chemo. He had continued neck pain and had further anterior cervical surgery (2012) followed by posterior surgery two weeks after the anterior cervical surgery. In December 2012, he had stabbing pain in his neck and was unable to see his primary pain management specialist. He received a prescription for pain medication from another physician and was fired from the pain management specialist. The posterior hardware was removed for hardware failure (2013). His pain management started with a new practice 04-21-2014. At that time he was being weaned from Morphine SR 100, and Percocet. At this time he has a question of instability at C1-C2. Current medications include Cymbalta, Amrix, MS Contin (since at least 4-21-2014), MSIR (morphine Sulfate Immediate Release-since at least 4-21-2014), and Exalgo (since at least 4-21-2014). In the provider notes of 06-13-2014, the injured worker complains of anterior neck pain with clicking and very painful swallowing. On examination there was 2+ paraspinal tenderness, 2+ spasm, and limited cervical motion. His diagnoses included postlaminectomy syndrome, cervical spine; myalgia, polyneuropathy malignant disease; history colon cancer, diabetes type II, depression, and insomnia. A urine screen was done due to inconsistencies with the last screening, and continued his current

medications. A request for authorization was submitted for 1. X-ray of the neck, 3 views 2. Morphine 30mg, Qty 150 3. 1 Urine Drug Toxicology 4. Exlago ER 12mg, Qty 60. A utilization review decision 06-24-2014 Authorized: 1 Urine Drug Toxicology- Exlago ER 12mg, Qty 60 Non-certified X-ray of the neck, 3 views Modified- Morphine 30mg, Qty 150 to Morphine 30mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray of the neck, 3 views: Overturned

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines -Upper Back and Neck (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Radiography (x-rays).

Decision rationale: Per the ODG guidelines regarding radiography: Not recommended except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria. Initial studies may be warranted only when potentially serious underlying conditions are suspected like fracture or neurologic deficit, cancer, infection or tumor. (Bigos, 1999) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007) There is little evidence that diagnostic procedures for neck pain without severe trauma or radicular symptoms have validity and utility. (Haldeman, 2008) Indications for imaging -- X-rays (AP, lateral, etc.): Cervical spine trauma, unconscious- Cervical spine trauma, impaired sensorium (including alcohol and/or drugs) Cervical spine trauma, multiple trauma and/or impaired sensorium. Cervical spine trauma (a serious bodily injury), neck pain, no neurological deficit- Cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet. Cervical spine trauma, alert, cervical tenderness. Chronic neck pain (= after 3 months conservative treatment), patient younger than 40, no history of trauma, first study. Chronic neck pain, patient younger than 40, history of remote trauma, first study. Chronic neck pain, patient older than 40, no history of trauma, first study. Chronic neck pain, patient older than 40, history of remote trauma, first study. Chronic neck pain, patients of any age,

history of previous malignancy, first study. Chronic neck pain, patients of any age, history of previous remote neck surgery, first study. Post-surgery: evaluate status of fusion. Per the medical records submitted for review, the injured worker underwent cervical spine radiographs with flexion and extension 1/28/14, which revealed no evidence of instability. CT of the cervical spine was performed 3/5/14 showing a mineralized fusion. Per progress report dated 4/21/14 that there was a question of instability at C1-C2. The injured worker has new pain with swallowing, is over 40, and has a history of malignancy. The request is medically necessary.

Morphine 30mg, qty 150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding on-going management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the '4 A's' (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Review of the available medical records reveals no documentation to support the medical necessity of morphine nor any documentation addressing the '4 A's' domains, which is a recommended practice for the on-going management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. UDS performed 6/20/14 was negative for opiates. As MTUS recommends to discontinue opioids if there is no overall improvement in function, medical necessity cannot be affirmed. Therefore, the requested treatment is not medically necessary.