

Case Number:	CM14-0187910		
Date Assigned:	11/18/2014	Date of Injury:	08/09/2007
Decision Date:	01/07/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	11/11/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 64-year-old woman who sustained a work related injury on August 9, 2007. Subsequently, she developed chronic neck and back pain. An EMG/NCV study performed on October 16, 2014 documented abnormal study. The Electrodiagnostic study revealed evidence of active-on-chronic right C5 radiculopathy. There was no Electrodiagnostic evidence of generalized peripheral neuropathy brachial plexopathy. Prior treatments included: medications (Norco, Norflex, Prilosec), acupuncture (with some relief), injections in her neck (helped reduce her pain significantly with last one done in 2008), and ACDF at C5-6 on November 29, 2011. According to a clinical report dated October 2, 2014, the patient complained of ongoing neck, mid, back, and bilateral upper extremity pain. She reported radiation of pain down her right arm to her wrist, which she rated as a 7-8/10. She stated weakness in the bilateral hands and noted dropping objects at times. She had more pain on the right arm. She reported neck pain with radiation into the distal shoulder, which she rated 8/10. She stated her pain is the most painful and has increased since her last visit. She reported spasms in her neck and back. Physical examination revealed Hoffman's negative right and left, Babinski negative right and left, Stranski's negative right and left. Reflexes were normal and symmetric. Straight leg raise negative right and left. Bowstring sign negative right and left. Cross leg raise negative right and left. Spurling's test positive right. Dermatomes C2-S2 intact to light touch and pinprick. There was limited cervical rotation/extension. The patient was diagnosed with cervical radiculopathy, cervical DDD, chronic neck pain status post-surgical fusion, cervical myofascial strain, and cervical HNP. The provider requested authorization for Norco, Hydrocodone/APAP, Fenoprofen Calcium, Fenoprofen, MRI cervical spine, and 12 physical therapy sessions with modalities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

Decision rationale: According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. 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 non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. There is no clear evidence of objective and recent functional and pain improvement with previous use of Norco (Norco has been used since at least February 2010). There is no clear documentation of the efficacy/safety and compliance of previous use of Norco. There is no clear justification for the need to continue the use of Norco. Therefore, the prescription of Norco 5/325mg #60 is not medically necessary.

Hydrocodone/APAP 5/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 179.

Decision rationale: According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions

from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: 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 non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. There is no documentation of functional and pain improvement with previous use of hydrocodone. There is no documentation of continuous compliance of patient to her medications. Therefore, the prescription of Hydrocodone/APAP 5/325mg #60 is not medically necessary.

Fenoprofen Calcium 400mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NON SELECTIVE NSAIDS Page(s): 72.

Decision rationale: There is no documentation of the rationale behind the long-term use of Fenoprofen. NSAID should be used for the shortest duration and the lowest dose. There is no documentation from the patient file that the provider titrated Fenoprofen to the lowest effective dose and used it for the shortest period possible. Naproxen was used without clear documentation of its efficacy. Furthermore, there is no documentation that the provider followed the patient for Fenoprofen adverse reactions that are not limited to GI side effect, but also may affect the renal function. Therefore, the request for Fenoprofen Calcium 400mg #120 is not medically necessary.

Fenoprofen 400mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NON SELECTIVE NSAIDS Page(s): 72.

Decision rationale: There is no documentation of the rationale behind the long-term use of Fenoprofen. NSAID should be used for the shortest duration and the lowest dose. There is no documentation from the patient file that the provider titrated Fenoprofen to the lowest effective

dose and used it for the shortest period possible. Naproxen was used without clear documentation of its efficacy. Furthermore, there is no documentation that the provider followed the patient for Fenoprofen adverse reactions that are not limited to GI side effect, but also may affect the renal function. Therefore, the request for Fenoprofen 400mg #120 is not medically necessary.

MRI cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

Decision rationale: According to MTUS guidelines, MRI of the cervical spine is recommended if there is clinical or neurophysiological evidence of disc herniation or an anatomical defect and if there is failure of therapy trials. There is no clinical evidence of anatomical defect or nerve compromise in this case. Therefore, the request for an MRI of cervical spine is not medically necessary.

12 physical therapy sessions with modalities: 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.

Decision rationale: According to MTUS guidelines, Physical Medicine is <Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated

by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007). There is no documentation of the efficacy and outcome of previous physical therapy sessions. There are no recent objective findings that support musculoskeletal dysfunction requiring more physical therapy. There is no documentation of pain improvement with previous physical therapy. There is no documentation that the patient cannot perform home exercise. Therefore, the prescription of 12 Physical Therapy sessions is not medically necessary.