

Case Number:	CM15-0043899		
Date Assigned:	04/17/2015	Date of Injury:	11/01/2003
Decision Date:	07/07/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	03/09/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 51-year-old female, who sustained an industrial injury on 11/01/2003. She was diagnosed with tendonitis of the right wrist and hand and then had a gradual development of an increase of symptoms to the neck. The injured worker was diagnosed as having right cervical radiculopathy, chronic pain status post cervical fusion, cervical facet arthropathy, cervical myofascial strain, cervicgia, cervical degenerative disc disease, and cervical stenosis. Treatment to date has included laboratory studies, medication regimen, physical therapy, acupuncture therapy, status post right flexor carpi radialis tenosynovectomy and partial scaphoid tubercle, status post cervical fusion at cervical five to six and cervical six to seven, status post cervical epidural steroid injection to cervical four to five, use of ice, use of heat, electromyogram of the bilateral upper extremities, magnetic resonance imaging of the cervical spine, and computed tomography of the cervical spine. In a progress note dated 12/09/2014 the treating physician reports complaints of constant, aching, and cramping pain in the muscles of the neck to the bilateral hands with a pain rating of a three to eight out of ten. The treating physician requested medications Ketoprofen cream (CM3-Ketoprofen 20%) for use over the paraspinal muscles, along with the requests for Percocet 10/325mg with a quantity of 90, Elavil 25mg with a quantity 60, and Mobic 15mg with a quantity 30, but the documentation provided did not indicate the specific reason for the requests of these medications. The treating physician requested psychologist pain consult for spinal cord stimulator trial clearance and a request for cervical spine imaging for updated imaging of the cervical spine in preparation for a spinal cord stimulator trail. The treating physician also requested an electromyogram of the bilateral upper extremities and urine drug screen, but the treating physician did not indicate the specific reason for the request of an electromyogram of the bilateral upper extremities and a urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for Percocet 10/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96 (78, 89, 95).

Decision rationale: Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, opioids should be continued if the patient has returned to work or has improved functioning and pain. Ongoing management actions should include prescriptions from a single practitioner, taken as directed and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. Documentation should follow the 4A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long-term users of opioids should be regularly reassessed. In the maintenance phase, the dose should not be lowered if it is working. Also, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected when this happens opioids can actually increase rather than decrease sensitivity to noxious stimuli. It is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. A review of the injured workers medical records reveal no real change in her pain level with the use of Percocet, there is no documentation of improvement in pain and function, she does not appear to be having a satisfactory response to Percocet and the continued use is not medically necessary.

1 prescription for Elavil 25mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 14-16.

Decision rationale: Per the MTUS, antidepressants are recommended as a first line option in the treatment of neuropathic pain and also possibly for non- neuropathic pain. "Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. (Saarto-Cochrane, 2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment." A review of the injured workers medical records that are available to me did not reveal documentation of improvement in pain or function with the use of Elavil and the continued use is not medically necessary.

1 prescription for Mobic 15mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 67-68.

Decision rationale: Per the MTUS, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. A review of the injured workers medical records reveal persistent pain with not much change despite the use of Mobic and the continued use is not medically necessary.

1 prescription for Ketoprofen cream (CM3-Ketoprofen 20%): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Per the MTUS, topical analgesics are recommended as an option, they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis. A review of the injured workers medical records that are available to me does not show a trial of recommended first line agents that have failed, therefore the request for 1 prescription for Ketoprofen cream (CM3-Ketoprofen 20%) is not medically necessary.

1 psychologist pain consult for spinal cord stimulator trial clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Neck & Upper Back (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).

Decision rationale: The MTUS does not address the use of spinal cord stimulator in the cervical spine therefore, other guidelines were consulted. Per the ODG, not recommended except as a last resort for two conditions, selected patients meeting detailed criteria with either Complex Regional Pain Syndrome (CRPS) Type I, or with Failed Back Surgery Syndrome (FBSS). Not recommended for any condition specific to the cervical spine. A review of the injured workers recent medical records reveal documentation that she is not interested in spinal cord stimulator as a treatment option and there is no evidence that she will meet the criteria for spinal cord stimulator implantation, especially since it is not recommended for the cervical spine therefore the request for 1 psychologist pain consult for spinal cord stimulator trial clearance is not medically necessary.

1 cervical spine imaging: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: Per the MTUS / ACOEM, "for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are: Emergence of a red flag, Physiologic evidence of tissue insult or neurologic dysfunction, Failure to progress in a strengthening program intended to avoid surgery and Clarification of the anatomy prior to an invasive procedure. A review of the injured workers medical records that are available to me do not reveal any red flags, surgical considerations or any of the above referenced criteria for imaging as recommended by the guidelines and therefore the request for imaging of the cervical spine is not medically necessary.

1 urine drug screen: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) / Urine Drug testing.

Decision rationale: Per the MTUS, Drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs before a therapeutic trial of opioids, during ongoing management and to avoid misuse/ addiction. Per the ODG, frequency of urine drug testing should be based on documented evidence of risk stratification including use of a testing instrument. A review of the injured workers medical records did not reveal documentation of risk stratification and without this information, urine drug test is not medically necessary.

1 EMG of bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic)/ Electrodiagnostic studies, Nerve conduction studies.

Decision rationale: Per ACOEM in the MTUS, most patients presenting with true neck and upper back problems do not need special studies until a 3-4 week period of conservative care fails to improve symptoms, most patients improve quickly once red-flag conditions are ruled out. Criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurological examination is less clear, however further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV may help identify subtle focal neurologic dysfunction in patients with neck and or arm symptoms lasting more than 3-4 weeks. Per the ODG, NCS are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. radiculopathy has already been clearly identified in this injured worker and therefore based on the guidelines the request for 1 EMG of bilateral upper extremities is not medically necessary.