

Case Number:	CM13-0033734		
Date Assigned:	12/06/2013	Date of Injury:	06/01/2013
Decision Date:	02/10/2014	UR Denial Date:	10/02/2013
Priority:	Standard	Application Received:	10/11/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation 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 physician 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 35 year old male who sustained an industrial injury on June 1, 2013. The patient injured his back and leg while lifting a heavy bale of foam. The patient has been treated with pain medications including Norco, Anaprox and Flexeril and physical therapy without help. On 9/13/13, the patient complained of pain in his back, buttocks to his left leg and weakness. He describes his pain to be 7/10 and average of 9/10 on most days. He was alert but distressed because the pain was making it difficult to get up from a chair. His physical examination showed radicular low back pain with left sacroilitis. The patient was advised at this visit to discontinue physical therapy because it appeared to be making his pain worse.

IMR ISSUES, DECISIONS AND RATIONALES

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

Initial drug screening and future random drug screening: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43 and 85.

Decision rationale: According to the Chronic pain guidelines, page 43, urine drug screening is recommended as an option to assess for the use or the presence of illegal drugs. Also page 85 of

MTUS states that urine drug screening is also used in Chelminski multi-disciplinary pain management program criteria: (Chelminski, 2005) Criteria used to define serious substance misuse in a multi-disciplinary pain management program: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. Therefore the request for initial drug screening and future random drug screenings was medically necessary.

Baseline functional capacity evaluation: 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), Fitness for Duty Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 132-139

Decision rationale: Although functional evaluations (FCE) are widely used and promoted, it is important for physicians and others to understand the limitations and pitfalls of these evaluations. Functional capacity examination may establish physical abilities and also facilitates the examinee/employer relationship for return to work. However, FCEs can be deliberately simplified evaluations based on multiple assumptions and subjective factors, which are not always apparent to their requesting physician. There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace: an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's ability. Therefore, the FCE is not medically necessary.

Genetic testing to assess for predisposition to narcotic addiction: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Pharmacogenetic and Pharmacodynamic Testing

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Cytokine DNA Testing

Decision rationale: The California MTUS/ACOEM Guidelines do not address this request. The ODG Pain Chapter, Genetic testing for potential opioid abuse, Cytokine DNA testing, states genetic testing for potential opioid abuse is not recommended. While there appears to be a strong genetic component to addictive behavior, current research is experimental in terms of testing for this. Studies are inconsistent, with inadequate statistics and large phenotype range. Different studies use different criteria for definition of controls. More work is needed to verify the role of variants suggested to be associated with addiction and for clearer understanding of

their role in different populations. Therefore, the request for retrospective request for a DNA test to assess for predisposition to narcotic addiction is not medically necessary.

left sacroiliac joint injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: Invasive techniques (such as sacroiliac joint injections) are of questionable merit. Despite the fact that proof is still lacking, many pain management physicians believe that the diagnostic and/or therapeutic injections may have a benefit in patients presenting in the transitional phase between acute and chronic pain. According to the ODG, SI joint injections are recommended as an option if patient fails at least 4-6 weeks of aggressive conservative therapy (such as at least 6 weeks of a comprehensive exercise program, local icing, mobilization/manipulation and anti-inflammatory medications). Sacroiliac dysfunction is poorly defined and usually the diagnosis is difficult to make due to presence of other low back pathology. This patient only has a positive Patrick's test and has only had physical therapy and medications. There is no documentation of at least 3 provocative maneuvers.