

Case Number:	CM13-0040131		
Date Assigned:	12/20/2013	Date of Injury:	09/28/2012
Decision Date:	02/11/2014	UR Denial Date:	09/26/2013
Priority:	Standard	Application Received:	10/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. He 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 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 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 injured worker is a 43-year-old female, with a date of injury of September 28, 2012. The assented body regions include both hands, both wrists, right shoulder, and neck. The current diagnoses include shoulder impingement, bilateral carpal tunnel syndrome, anxiety. Treatment to date has included physical therapy and medications. An EMG/NCS was performed on 11/21/12 which demonstrated right carpal tunnel syndrome. Cervical MRI for this injured worker was performed on February 1, 2013. At C5-6, there was a 3 to 4 mm posterior disc bulge that he faced the ventral surface of the thecal sac resulting in severe right and moderate left neuroforaminal stenosis in conjunction with uncle vertebral osteophyte formation. At C6-7, there was a 2 to 3 mm posterior disc bulge which effaced the ventral surface of the thecal sac without evidence of canal stenosis or neuroforaminal narrowing. There is no evidence of signal abnormality within the central cord at any of the levels. In a note on date of service September 10, 2013 the requesting healthcare provider ordered electrodiagnostic studies of the upper extremity to confirm carpal tunnel syndrome, right worse than left. There is also a request for second epidural steroid injection and "probably a third epidural injection of the cervical spine." It is noted in this same note that the patient received "5 to 6 weeks of relief." The patient underwent a repeat electrodiagnostic study on date of service September 25, 2013. The results suggested minimal primary sensory demyelinating right carpal tunnel syndrome as well as bilateral chronic active C5 and C6 radiculopathy, right-sided greater than left side. Utilization review has denied the request for cervical epidural steroid injection, topical creams, electrodiagnostic studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topical creams Tramadol: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines, on pages 111-113, specify the following regarding topical Analgesics: "Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, $\hat{1}\pm$ -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, $\hat{1}^3$ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. [Note: Topical analgesics work locally underneath the skin where they are applied. These do not include transdermal analgesics that are systemic agents entering the body through a transdermal means. See Duragesic[®] (fentanyl transdermal system).]" In the case of topical tramadol, there are no provisions for this topical formulation in the California Medical Treatment and Utilization Schedule. In these cases, national, evidence based standards of care are applied. Topical ketoprofen does not have peer-reviewed blinded studies to support its use and is recommended for non-certification.

Topical creams Ketoprofen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. (Diaz, 2006) (Hindsen, 2006) Absorption of the drug depends on the base it is delivered in. (Gurol, 1996). Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. (Krummel 2000)" Given the guidelines, the request for topical ketoprofen is recommended for non-certification.

Topical creams Gabapentin: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: On page 113 of the Chronic Pain Medical Treatment Medical Guidelines, the following is stated: "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." Therefore, the request for topical gabapentin is not recommended.

Upper extremity EMG, right: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-178, 271-273, Chronic Pain Treatment Guidelines Code of Regulations Page(s): 4.

Decision rationale: With regard to EMG/NCS of the upper extremities, Section Â§ 9792.23.1 Neck and Upper Back Complaints of the California Code of Regulations, Title 8, page 4 states the following: "The Administrative Director adopts and incorporates by reference the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8) into the MTUS from the ACOEM Practice Guidelines." Furthermore, Section Â§ 9792. 23.4 Forearm, Wrist, and Hand Complaints of California Code of Regulations, Title 8, page 5 states the following: "The Administrative Director adopts and incorporates by reference the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) into the MTUS from the ACOEM Practice Guidelines." ACOEM Chapter 8 Neck and Upper Back Complaints contains the following discussion of electrodiagnostic testing on pages 177-178: "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 neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected." The ACOEM Guidelines on pages 271-273 includes Table 11-7 entitled "Summary of Recommendations and Evidence." With regard to detection of neurologic abnormalities, there is a recommendation of nerve conduction studies for median (B) or ulnar (C) impingement at the wrist after failure of conservative treatment. There is recommendation against "routine use of NCV or EMG in diagnostic evaluation of nerve entrapment or screening in patients without

symptoms(D)." In the case of this injured worker, the request for repeat EMG is not clinically necessary per guidelines. In the case of obvious radiculopathy, electrodiagnostic studies are not warranted. The injured worker already had a previous electrodiagnostic study in 2012 that demonstrated carpal tunnel syndrome. Thus the request for repeat EMG is recommended for noncertification.

Upper extremity EMG, left: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-178, 271-273, Chronic Pain Treatment Guidelines Code of Regulations Page(s): 4.

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Upper extremity NCS, right: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-178, 271-273.

Decision rationale: With regard to EMG/NCS of the upper extremities, Section Â§ 9792.23.1 Neck and Upper Back Complaints of the California Code of Regulations, Title 8, page 4 states the following: "The Administrative Director adopts and incorporates by reference the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8) into the MTUS from the ACOEM Practice Guidelines." Furthermore, Section Â§ 9792. 23.4 Forearm, Wrist, and Hand Complaints of California Code of Regulations, Title 8, page 5 states the following: "The Administrative Director adopts and incorporates by reference the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) into the MTUS from the ACOEM Practice Guidelines." ACOEM Chapter 8 Neck and Upper Back Complaints contains the following discussion of electrodiagnostic testing on pages 177-178: "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 neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected." The ACOEM Guidelines on pages 271-273 includes Table 11-7 entitled "Summary of Recommendations and Evidence." With regard to detection of neurologic abnormalities, there is a recommendation of nerve conduction studies for median (B) or ulnar (C) impingement at the wrist after failure of conservative treatment. There is recommendation against "routine use of NCV or EMG in diagnostic evaluation of nerve entrapment or screening in patients without symptoms(D)." In the case of this injured worker, the request for repeat NCS is not clinically necessary per guidelines. In the case of obvious radiculopathy, electrodiagnostic studies are not warranted. The injured worker already had a previous electrodiagnostic study in 2012 that demonstrated carpal tunnel syndrome. Thus the request for repeat NCS is recommended for noncertification.

Upper extremity NCS, left: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-178, 271-273, Chronic Pain Treatment Guidelines Code of Regulations Page(s): 4.

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Cervical epidural steroid injection at c4-c5: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Injections Page(s): 47.

Decision rationale: The California Medical Treatment and Utilization Schedule specifies on page 47 of the Chronic Pain Medical Treatment Guidelines the following regarding Epidural steroid injections (ESIs) "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome.

Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.

Cervical epidural steroid injection at c5-c6: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Injections Page(s): 47.

Decision rationale: The California Medical Treatment and Utilization Schedule specifies on page 47 of the Chronic Pain Medical Treatment Guidelines the following regarding Epidural steroid injections (ESIs) "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The

American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.

Cervical epidural steroid injection at c6-c7: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 47.

Decision rationale: The California Medical Treatment and Utilization Schedule specifies on page 47 of the Chronic Pain Medical Treatment Guidelines the following regarding Epidural steroid injections (ESIs) "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any

recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.

Consult with pain management for epidural injections: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 127.

Decision rationale: The request for pain management is not specifically address in the California Medical Treatment and Utilization Schedule. American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, Second Edition state the following on page 127: "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. When a physician is responsible for performing an isolated assessment of an examinee's health or disability for an employer, business, or insurer, a limited examinee-physician relationship should be considered to exist. A referral may be for: Consultation: To aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient." The injured worker in this case have had long-standing chronic pain. She continues with significant pain from cervical radiculopathy and carpal tunnel syndrome. Pain management consultation at follow-up is appropriate at this stage. In this case, an issue of semantics may play an issue. The utilization review performed on September 26, 2013 states that "anything consult was already done; the need for another consult is not shown. A follow-up to clarify the best treatment approach is supported." The requesting healthcare provider had specified for a pain consult, which might have meant a follow-up. However, some practitioners

interpret consult to imply a new visit. Regardless of what was intended, this injured worker should be allowed to follow up with pain management services.

Urine toxicology: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Testing Page(s): 43.

Decision rationale: The Chronic Pain Medical Treatment Medical Guidelines state the following regarding urine drug testing on page 43: "Drug testing: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. For more information, see Opioids, criteria for use: (2) Steps to Take Before a Therapeutic Trial of Opioids & (4) On-Going Management; Opioids, differentiation: dependence & addiction; Opioids, screening for risk of addiction (tests); & Opioids, steps to avoid misuse/addiction." The sections cited above are excerpted below from pages 76-80 of the Chronic Pain Medical Treatment Medical Guidelines: "2) Steps to Take Before a Therapeutic Trial of Opioids: (a) Attempt to determine if the pain is nociceptive or neuropathic. Also attempt to determine if there are underlying contributing psychological issues. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain. (b) A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. (c) Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. (d) Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. See Function Measures. (e) Pain related assessment should include history of pain treatment and effect of pain and function. (f) Assess the likelihood that the patient could be weaned from opioids if there is no improvement in pain and function. (g) The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. When subjective complaints do not correlate with imaging studies and/or physical findings and/or when psychosocial issue concerns exist, a second opinion with a pain specialist and a psychological assessment should be obtained. (h) The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian. (i) A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain. See Guidelines for Pain Treatment Agreement. This should include the consequences of non-adherence. (j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs. 4) On-Going Management. Actions Should Include: (a) Prescriptions from a single pra