MAXIMUS Federal Services

Case Number:	CM14-0134699		
Date Assigned:	08/27/2014	Date of Injury:	02/10/2012
Decision Date:	10/22/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	08/21/2014

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 Orthopedic Surgery, and is licensed to practice in Indiana. 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 injured worker is a 49-year-old female who had a date of injury of 12/10/12. An MRI of the lumbar spine dated 6/29/14 was interpreted as L4-5 mild diffuse disc herniation causing mild spinal stenosis with associated bilateral lateral recess stenosis impinging on the L5 transiting nerve roots bilaterally. There was also hypertrophy of bilateral facets and ligamentum flava noted, with disc material and facet hypertrophy causing stenosis of the bilateral neural foramina contacting the exiting right L4 nerve root. The MRI also showed mild mild spinal stenosis with bilateral facet hypertrophy at L1-2, L2-3, L3-4, and L5-S1. The MRI was ordered due to a clinical history of pain radiating down legs, muscle weakness, and numbness and tingling radiating down both legs. On a physical examination dated 7/14/14, the worker had neck, mid back, low back, bilateral shoulder and left elbow pain. The worker had tenderness of the cervical spine with decreased ROM. The worker also had tenderness of both anterior glenoid and the left AC joint. ROM of the left shoulder was decreased. Neer and Hawkin's tests were positive on the left side and the worker had bilateral Tinel's at the elbows and Phalen's at the wrist. The examination of the lumbar spine revealed tenderness and guarding with decreased lumbar flexion of 60 degrees, and extension and lateral bending to 20 degrees. The worker had a positive Lasegue's bilaterally. Diagnoses include cervical sprain/strain; Thoracic sprain/strain; Lumbar sprain/strain; right rotator cuff sprain/strain; and left ulnar nerve entrapment. The treating physician is requesting approval for x-rays of the lumbar spine, left shoulder, left elbow, thoracic spine, an anterior lumbar interbody fusion of L4-5, and a urine test to monitor the worker's intake of prescribed narcotic medication. The worker has been under treatment by the treating physician since at least 1/28/14. There is a documented urine drug screen result from 4/28/14 with the claimant having no evidence of narcotics and their metabolites in her urine despite being prescribed Tylenol #3.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-Ray lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 - 304.

Decision rationale: According to the ACOEM guidelines for Low Back Complaints, Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. In this worker's, an MRI of the lumbar spine, a more sensitive, has already been performed and the plain radiographs of the lumbar spine would not add additional information. In addition, there is not adequate documentation in the medical records of the worker having failed a comprehensive conservative program. For these reasons, an x-ray of the lumbar spine is not medically necessary.

X-Ray left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207 - 208.

Decision rationale: According to the ACOEM guidelines for shoulder complaints, routine testing (laboratory tests, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. Cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. In addition, Primary criteria for ordering imaging studies are: Emergence of a red flag (e.g., indications of intra-abdominal or cardiacproblems presenting as shoulder problems) Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon) Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). Since there is no record in the medical records of the worker having been treated with a comprehensive conservative treatment program and none of the primary

criteria for ordering imaging studies of the shoulder have been met, the requested x-ray of the left shoulder is not medically necessary.

X-Ray left elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 602.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (Acute and Chronic), Radiography

Decision rationale: According to the ODG Guidelines for the elbow, radiography is recommended and may be diagnostic for osteochondral fracture, osteochondritis dissecans, and osteocartilaginous intra-articular body. (ACR, 2001) Those patients with normal extension, flexion and supination do not require emergent elbow radiographs. In this worker's case the worker has documented normal range of motion of the elbows and does not have evidence of osteochondral fracture, osteochondritis dissecans, or osteocartilaginous loose body. For this reason, this worker does not meet the guideline criteria for radiographs of the elbow and the requested elbow x-ray is not medically necessary. CA MTUS and ACOEM (2004) Guidelines are silent regarding elbow x-rays for ulnar nerve entrapment of the elbow. This request is not medically necessary.

X-Ray thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: According to the ACOEM guidelines for Neck and Upper Back Complaints, Radiography, initial radiographic studies are recommended when red flags for fracture, or neurologic deficits associated with acute trauma, tumor, or infection are present. Since none of these red flags are present in the medical records, the requested x-ray of the thoracic spine is not medically necessary.

Anterior lumbar interbody fusion of L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back: Lumbar and Thoracic (Acute and Chronic), Fusion (Spinal)

Decision rationale: According to the ODG criteria for lumbar fusion: lumbar fusion is not recommended for patients who have less than six months of failed recommended conservative care unless there is objectively demonstrated severe structural instability and/or acute or progressive neurologic dysfunction, but recommended as an option for spinal fracture, dislocation, spondylolisthesis or frank neurogenic compromise, subject to the selection criteria outlined in the section below entitled, "Patient Selection Criteria for Lumbar Spinal Fusion," after 6 months of conservative care. Patient Selection Criteria for Lumbar Spinal Fusion: For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, with relative angular motion greater than 20 degrees. (Anderson, 2000) (Luers, 2007)] (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. Spinal instability criteria includes lumbar inter-segmental movement of more than 4.5 mm. (Anderson, 2000) (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See ODG Indications for Surgery -- Discectomy.) Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram or discography, the worker does not meet criteria for a lumbar fusion. Therefore, the requested anterior lumbar interbody fusion of L4-5 is not medically necessary.

Urine test: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction Page(s): 94-95.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM V.3, Opioids Guideline (2014) Diagnostics and Monitoring

Decision rationale: According to the ACOEM V.3 Opioid Guidelines, Diagnostics and Monitoring, Urine drug testing is recommended by the Federation of State Medical Boards in its Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain.(72) Urine drug

testing of patients being prescribed chronic opioids is part of proper medical practice, and should be a covered expense. This worker was initially started on Tylenol #3 on 3/17/14 and was subsequently switched to Norco 10/325 mg, another narcotic. The worker has undergone one urine drug screen performed on 4/28/14, which showed no evidence of narcotics or their metabolites in the worker's tested urine despite being prescribed narcotic medication. This could raise the possibility of diversion of narcotics by the worker and would be an additional reason for continued regular drug screens. For these reasons, the request for urine testing for drug screens in this worker who is being maintained on chronic narcotic medication is medically necessary.