

Case Number:	CM14-0172837		
Date Assigned:	10/23/2014	Date of Injury:	09/10/2005
Decision Date:	12/12/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/20/2014

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 Internal Medicine, has a subspecialty in Nephrology 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 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:

Patient is a 44-year-old male who has submitted a claim for carpal tunnel syndrome, cervical spondylosis without myelopathy, lumbar spine multilevel degenerative disc disease, disorders of bursa and tendons of shoulder, and depressive disorder associated with an industrial injury date of 9/10/2005. Medical records from 2014 were reviewed. Patient complained of total body pain rated 9/10 in severity. A psychiatrist was seeing him for depression. He reported neck pain radiating to bilateral upper extremities. Patient likewise experienced severe back pain radiating to the right lower extremity. There was no evidence of abuse, misuse and diversion from medication use. Physical examination of the cervical spine and lumbar spine showed muscle spasm and stiffness. Range of motion was restricted. There was tenderness at the trapezius and paralumbar muscles. Sensation was diminished at the right L4 to L5 and L5 to S1 dermatomes. X-ray of the lumbar spine, dated 8/26/2014, showed minimal levoscoliosis. X-ray of the cervical spine, dated 8/26/2014, revealed lucency of the graft at C5 to C6, solid fusion at C3 to C4, and artificial disks at C6 to C7 and C7 to T1 levels. MRI of the cervical spine dated 1/19/2006, showed disc protrusion at C2 to C4 level. MRI of the lumbar spine from 6/28/2007 showed normal findings. Urine drug screen from 3/27/2014 showed consistent results with prescription medications. Treatment to date has included cervical fusion surgery, acupuncture, chiropractic care, cervical epidural steroid injection 2008, and cervical facet injection in 2008, radiofrequency neurotomy at the cervical area, physical therapy, and medications such as Ambien, Flexeril, oxycodone, and OxyContin. Utilization review from 10/07/2014 denied the request for physical therapy 2 x 6 to lumbar and cervical spine because of no documented benefits from previous therapy sessions; denied lumbar and cervical ESI because of no diagnostics to corroborate findings for radiculopathy; and denied urine toxicology quantitative and confirmatory testing because there was no assessment of risk factors for aberrant behavior.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 x6 to lumbar and cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 103.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: As stated on pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. The guideline recommends 8 to 10 physical therapy visits over 4 weeks for neuralgia, neuritis, and radiculitis. In this case, patient was able to complete a course of physical therapy previously. However, the patient's response to treatment was not discussed. There was no objective evidence of overall pain improvement and functional gains derived from therapy. It was unclear why patient could transition into a home exercise program to address residual deficits. Moreover, there were no recent reports of acute exacerbation or progression of symptoms that would warrant additional course of treatment. Therefore, the request for physical therapy 2 x 6 for the lumbar and cervical spine was not medically necessary.

Lumbar ESI: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. In this case, patient experienced severe back pain radiating to the right lower extremity. Physical examination of the lumbar spine showed muscle spasm and stiffness. Range of motion was restricted. Sensation was diminished at the right L4 to L5 and L5 to S1 dermatomes. MRI of the lumbar spine from 6/28/2007 showed normal findings, based on utilization review report. However, there was no complete neurologic examination to document presence of radiculopathy. There was likewise no recent radiographic imaging to document presence of nerve root impingement. The request also failed to specify intended level for

injection. Guideline criteria were not met. Therefore, the request for lumbar ESI was not medically necessary.

Cervical ESI: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.26, Epidural Steroid Injection Page(s): 46.

Decision rationale: As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, Epidural Steroid Injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. In this case, patient reported neck pain radiating to bilateral upper extremities. Physical examination of the cervical spine showed muscle spasm and stiffness. Range of motion was restricted. MRI of the cervical spine, dated 1/19/2006, showed disc protrusion at C2 to C4 level. However, there was no complete neurologic examination to document presence of radiculopathy. There was likewise no recent radiographic imaging to document presence of nerve root impingement. The request also failed to specify intended level for injection. Moreover, patient underwent cervical ESI in 2008 without documentation concerning pain relief. Guideline criteria were not met. Therefore, the request for cervical ESI was not medically necessary.

Urine toxicology: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 44.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter; Urine Drug Testing, Opioids, tools for risk stratification & monitoring

Decision rationale: Page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that urine drug screens are recommended as an option to assess order use or presence of illegal drugs and as ongoing management for continued opioid use. Screening is recommended randomly at least twice and up to 4 times a year. The Official Disability Guidelines classifies patients as 'moderate risk' if pathology is identifiable with objective and subjective symptoms to support a diagnosis, and there may be concurrent psychiatric comorbidity. Patients at moderate risk for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. In this case, the patient can be classified as 'moderate risk' as he was diagnosed with depressive disorder. Current

treatment regimen includes Ambien, Flexeril, oxycodone, and OxyContin. Urine drug screen from 3/27/2014 showed consistent results with prescription medications. Patient meets guideline criteria for drug screening given that he is currently on opioids and has psychiatric comorbidity. Therefore, the request for random urine toxicology is medically necessary.