MAXIMUS Federal Services

Case Number:	CM14-0082031		
Date Assigned:	07/21/2014	Date of Injury:	06/01/2010
Decision Date:	08/27/2014	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	06/03/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 41-year-old female with date of injury of 06/01/2010. The listed diagnoses per [redacted] dated 03/26/2014 are: 1. Cervical disk disease. 2. Cervical radiculopathy. 3. Cervical facet syndrome. According to this report, the patient complains of stiffness and pain in her neck with headaches, which she rates 7/10. She reports that sometimes she can hardly move her neck. The pain radiates to the bilateral shoulders. She also complains of bilateral hand pain radiating to the elbows. Her current list of medications includes Vicodin, naproxen, and Maxzide. The physical exam shows the patient is well- developed, well-nourished in no apparent distress. There is midline abnormal lordosis. There is moderate tenderness with spasm over the cervical paraspinal musculature. Axial head compression is positive bilaterally. Spurling sign is positive bilaterally. There is facet tenderness noted from C5-C7. Sensation is decreased in the right C6 and left C7 dermatomes. The MRI of the cervical spine dated 03/04/2013 shows a 2- to 3-mm posterior C5-C6 disk protrusion and a 3-mm left posterior paracentral C5-C7 disk herniation which flattens the anterior thecal sac and is responsible for a mild left C6-C7 lateral recess stenosis. The patient is 20 weeks pregnant. The utilization review denied the request on 05/02/2012.

IMR ISSUES, DECISIONS AND RATIONALES

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

URINE TOXICOLOGY SCREENING: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment Guidelines, Drug testing (MTUS pg 43) 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. 4) On-Going Management. Actions Should Include: (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Opioids, differentiation: dependence & addiction 3) 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. Opioids, steps to avoid misuse/addiction The following are steps to avoid misuse of opioids, and in particular, for those at high risk of abuse:
a) Opioid therapy contracts. See Guidelines for Pain Treatment Agreement. b) Limitation of prescribing and filling of prescriptions to one pharmacy. c) Frequent random urine toxicology screens. d) Frequent evaluation of clinical history, including questions about cravings for the former drug of abuse (a potential early sign of relapse). e) Frequent review of medications (including electronic medical record evaluation when available and pill counts at each visit, brought in the original bottle from the pharmacy). f) Communication with pharmacists.
g) Communication with previous providers and other current providers, with evidence of obtaining medical records. (It has been recommended that opioids should not be prescribed on a first visit until this step has been undertaken.) h) Evidence of participation in a recovery program (12-step or follow-up with a substance abuse counselor), such as speaking to his/her sponsor for the 12-step program. i) Establishment of goals of treatment that can be realistically achieved.
j) Initiation of appropriate non-opioid adjunct medications and exercise programs. k) Utilize careful documentation, and in particular, that which is recommended in the State in which opioids are prescribed. l) Incorporate family and friends for support and education. MTUS p77, under opioid management: (j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs., page 43 and on the Non-MTUS Official Disability Guidelines (ODG) ODG guidelines have the following regarding Urine Drug Screen: Criteria for Use of Urine Drug Testing Urine drug tests may be subject to specific drug screening statutes and regulations based on state and local laws, and the requesting clinician should be familiar with these. State regulations may address issues such as chain of custody requirements, patient privacy, and how results may be used or shared with employers. The rules and best practices of the U.S. Department of Transportation should be consulted if there is doubt about the legally defensible framework of most jurisdictions. (DOT, 2010) 1. A point-of-contact (POC) immunoassay test is recommended prior to initiating chronic opioid therapy. This is not recommended in acute care situations (i.e. for treatment of nociceptive pain). There should be documentation of an addiction-screening test using a formal screening survey in the records prior to initiating treatmen.

Decision rationale: This patient complains of stiffness and pain in her neck with associated headaches. The treater is requesting a urine toxicology screening. While the MTUS Guidelines do not specifically address how frequent urine drug screen should be obtained for various risk opiate users, ODG Guidelines provide a clear guideline. For low-risk opiate users, a yearly urine drug screen is recommended following the initial screening within the first 6 months. The progress report dated 03/26/2014 documents that the patient is currently not taking any medications due to her 20-week pregnancy. The records do not show any recent UDS. In this case, the patient is not taking any opiates and a urine drug screen does not appear indicated. Recommendation is for denial.

RIGHT C5-C6 AND LEFT C6-C7 TRANSFACET EPIDURAL STEROID INJECTION X 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESI'S).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment Guidelines, Chronic Pain Medical Treatment Guidelines The Medical Treatment Utilization Schedule has the following regarding ESI's, under its chronic pain section: Page 46,47 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)

8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. MTUS 9792.2 definitions, p11 (4) Surgery means a procedure listed in the surgery chapter of the Official Medical Fee Schedule with follow-up days of 90 days., page 46-47.

Decision rationale: This patient complains of stiffness and pain in her neck with associated headaches. The treater is requesting right C5-C6 and left C6-C7 transfacet epidural steroid injection x2. The MTUS Guidelines page 46 and 47 on epidural steroid injection states that it is recommended as an option for treatment of radicular pain as defined by pain in a dermatomal distribution with corroborative findings of radiculopathy in an MRI. In addition, no more than 2 nerve levels should be injected using transforaminal blocks and no more than 1 interlaminar level should be injected at 1 session. The MRI dated 03/04/2013 showed a C5-C6 2- to 3-mm posterior disk protrusion and a 3-mm left posterior disk herniation at C6-C7. The progress report dated 03/26/2014 show a positive axial head compression test and Spurling's sign. There is also decreased sensation on the right C6 and left C7 dermatomes. The records do not show that the patient has had any previous transfacet epidural steroid injection. In this case, while the patient presents with a positive exam and imaging study, the requested 2 ESI exceeds MTUS recommendations. Recommendation is for denial.

CERVICAL TRACTION UNIT FOR HOME USE: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Practice Guidelines, Chapter 8 Neck and Upper Back Complaints, page 173 and on the Non-MTUS Official Disability Guidelines (ODG) ODG-twc guidelines has the following regarding cervical traction units: (http://www.odg-twc.com/odgtwc/neck.htm) Recommend home cervical autotraction (patient controlled) devices for patients with radicular symptoms, but not powered traction devices. Several studies have demonstrated that home cervical traction can provide symptomatic relief in over 80% of patients with mild to moderately severe (Grade 3) cervical spinal syndromes with radiculopathy. (Aetna, 2004) (Olivero, 2002) (Joghataei, 2004) (Shakoor, 2002) Patients receiving intermittent traction performed significantly better than those assigned to the no traction group in terms of pain, forward flexion, right rotation and left rotation. (Zylbergold, 1985) Other studies have concluded there is limited documentation of efficacy of cervical traction beyond short-term pain reduction. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. (Kjellman, 1999) (Gross-Cochrane, 2002) (Aker, 1999) (Bigos, 1999) (Browder, 2004) For decades, cervical traction has been applied widely for pain relief of neck muscle spasm or nerve root compression. It is a technique in which a force is applied to a part of the body to reduce paravertebral muscle spasms by stretching soft tissues, and in certain circumstances separating facet joint surfaces or bony structures. Cervical traction is administered by various techniques ranging from supine mechanical motorized cervical traction to seated cervical traction using an over-the-door pulley support with attached weights. Duration of cervical traction can range from a few minutes to 30 min, once or twice weekly to several times per day. In general, over-the-door traction at home is limited to providing less than 20 pounds of traction. Note: Powered traction devices, such as VAX-D, DRX and Lordex, are considered a form of traction. See also the Low Back Chapter, where Traction is Not recommended.

Decision rationale: This patient complains of stiffness and pain in her neck with associated headaches. The treater is requesting a cervical traction unit for home use. The ACOEM Guidelines page 173 states that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction. However, the ODG Guidelines under traction states, "Recommend home cervical patient controlled traction (using a seated over-the-door device or a supine device, which may be preferred due to greater forces), for patients with radicular symptoms, in conjunction with a home exercise program." Several studies have demonstrated that home cervical traction can provide symptomatic relief in over 80% of patients with mild to moderately severe (Grade 3) cervical spinal syndromes with radiculopathy. In this case, ODG does recommend the use of a cervical traction device for patients presenting with radicular symptoms, which this patient has. Recommendation is for authorization.