

<b>Case Number:</b>	CM15-0131160		
<b>Date Assigned:</b>	07/17/2015	<b>Date of Injury:</b>	08/28/2012
<b>Decision Date:</b>	08/17/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 53-year-old male, who sustained an industrial injury on 8/28/12. Initial complaints were not reviewed. The injured worker was diagnosed as having left sacroiliac joint dysfunction; L3-S1 disc displacement; right L3 radiculopathy/left leg radiculopathy; right L3-4 moderate foraminal stenosis/moderate central stenosis L4-S1; status post left L4-5/L5-S1 laminotomy mesial facetectomy/foraminotomy and right L3 foraminotomy. Treatment to date has included status post left L4-5/L5-S1 laminotomy mesial facetectomy/foraminotomy and right L3 foraminotomy (8/28/13); physical therapy; trigger point injection/lumbosacral junction (1/22/15); left SI joint arthrogram /steroid injection (2/16/15); urine drug screening (1/22/15); medications. Diagnostics studies included MRI lumbar spine (9/5/12; 3/9/15); X-rays lumbar spine (6/23/14; 1/22/15); left sacroiliac joint arthrogram (2/16/15). Currently, the PR-2 notes dated 6/15/15 indicated the injured worker was approved for a pain management consultation and right L3 and L4 selective nerve root block and is currently pending scheduling. He complains of low back pain bilaterally at the L5-S1 region as well as right -sided buttock pain over the sacroiliac joint. He also has pain radiating into the right groin. He has no radiating leg pain. He rates his symptoms at 7-8/10 without medications and is reduced to 5-6/10 with medications. His current medications are listed as Norco 10/325mg; Soma 350mg; Lunesta 3mg and Prilosec DR 20mg. He is a status post left L4-5 and L5-S1 laminotomy, facetectomy and foraminotomy and right L3 foraminotomy of 8/28/13. He walks with a normal gait with normal heel-toe swing through gait and no evidence of a limp. There is evidence of tenderness to palpation over the right sacroiliac joint. Vascular and sensory are normal and intact. Provocative

sacroiliac joint test is positive for pain on the right with pelvic distraction and compression. A MRI of the lumbar spine impression reveals mild levoscoliosis of the lumbar spine, suggestion of a 2mm AP dimension right paramedian disc herniation T11-T12. This is not imaged in the axial plane, which limits evaluation. There are multilevel disc desiccations. He is a status post right- sided hemilaminectomy L3-L4 and left-sided hemilaminectomy L5-S1 with enhancing granulation tissue extending into the spinal canal and right neural foramina consistent with postoperative epidural fibrosis without recurrent or residual disc herniation. Moderate right-sided intervertebral neural foramina stenosis and bilateral facet joint arthritic changes are viewed. There are left-sided facet joint arthritic changes at L4-L5. PR-2 notes dated 2/5/15 indicate the injured worker has signed a contract for opioid prescribed medications use. The provider is requesting authorization of follow-up visit with pain management; random urine toxicology screen; selective nerve root block right L3, L4 which was authorized prior.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Random Urine Toxicology screen:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, and Pain Agreement.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine toxicology testing Page(s): 76-79.

**Decision rationale:** Regarding the request for a urine toxicology test, CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option in patients on controlled substances. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. There risk stratification is an important component in assessing the necessity and frequency of urine drug testing. With the documentation available for review, there is documentation of prescription of controlled substances in Norco and Soma. Urine drug testing has been carried out in January 2015. It does not appear there has been excessive testing, and random, unpredictable urine drug testing is standard part of opioid surveillance. Given this, this request is medically necessary.

**SNRB right L3, L4:** Upheld

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

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

**Decision rationale:** A selective nerve root block is essentially a transforaminal epidural steroid injection in which the medication is spread more peripherally along the exiting nerve root rather than centrally in the epidural space. Regarding the request for lumbar epidural

steroid injection/selective nerve root block, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, after failure of conservative treatment. Guidelines recommend that no more than one interlaminar level or two transforaminal levels should be injected in one session. Within the documentation available for review, there are recent subjective complaints or objective examination findings supporting a diagnosis of radiculopathy. However, the 3/9/15 MRI demonstrated granulation tissue at L3-4, but there is no clear pathology identified at L4-5. This is the level of the proposed L4 SNRB, which exits at this neuroforamen. Given this, the currently requested lumbar epidural steroid injection is not medically necessary.

**Follow up visit X1 with pain management:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127.

**Decision rationale:** With regard to the request for specialty consultation, the CA MTUS does not directly address specialty consultation. The ACOEM Practice Guidelines Chapter 7 recommend expert consultation when "when the plan or course of care may benefit from additional expertise." Thus, the guidelines are relatively permissive in allowing a requesting provider to refer to specialists. In the case of this injured worker, there remains chronic pain and limitations. The patient continues on opioid pain medications and has radicular pains. It is appropriate to continue seeking care with a pain management physician treatment given this clinical picture. This request is medically necessary.