

Case Number:	CM14-0097275		
Date Assigned:	07/28/2014	Date of Injury:	06/04/2003
Decision Date:	09/19/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	06/25/2014

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 and is licensed to practice in Illinois. 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 46-year-old male who reported an injury on 06/04/2003 due to an unknown mechanism. The injured worker is diagnosed with cervical spine multilevel disc bulges, left upper extremity radiculopathy, status post spine fusion at L3-4 and L4-5, status post lumbar hardware removal on 12/21/2007, anxiety, status post implantation of electrical stimulator, and discogenic back pain. The injured worker utilizes a pain stimulator device and medications. He also utilizes a brace for the lumbar spine. The injured worker uses medications, rest, activity modification, and heat for symptoms of pain. Home exercise programs were being utilized. On 05/08/2014 the injured worker received a Proove urine drug test indicating a score of 18. This is a medium risk for use of opioids. An open cervical MRI on 10/14/2010 noted a 2mm posterior disc protrusion at C3-4 and C5-6 with no stenosis, a 2-3mm posterior disc protrusion at C4-5 with lateral recess stenosis bilaterally, and a 4mm posterior disc protrusion with stenosis at C6-7. An EMG/NCV study on 02/09/2011 reveals evidence of mild acute C6 radiculopathy on the left. In addition, there is mild/borderline slowing of the right ulnar nerve across the elbow, unaccompanied by denervation in the ulnar supplied muscles of uncertain significance. An EMG/NCV study of the upper extremities dated 10/10/2012 noted left chronic C6 radiculopathy. There was no electrodiagnostic evidence of mononeuropathy involving the median, ulnar, and radial nerves. The injured worker underwent a lumbar spine fusion at L3-4 and L4-5, lumbar hardware removal on 12/21/2007, and implantation of electrical stimulator. On 07/31/2014, the injured worker presented with complaints of constant pain in his left shoulder which he described as aching, stabbing, and pulsing. He rated his pain as 5/10, describing numbness and tingling in the left arm and fingers. The pain was reported as constant and constant pain to his neck which he describes as sharp, stabbing, and aching. He rated this pain as 7/10 to 8/10, with complaints of numbness and tingling in the arms, fingers, and left

shoulder. The pain was constant and located from the neck to between his shoulder blades. Complaints to the back were bilateral in nature with the left side greater than right. He described this pain as sharp, aching, and stabbing. He rated this pain 7/10. He reported complaints of numbness and tingling to bilateral lower extremities noting the pain was constant and also reported instability of bilateral lower extremities, with his legs failing him. The injured worker also reported difficulty sleeping due to pain, sexual functioning, headaches, symptoms of anxiety related to pain and loss of work, symptoms of depression, decreased muscle mass and strength, decreased energy levels, and numbness with tingling. Activities of daily living aggravate this pain. The physician noted the injured worker had an antalgic gait, favoring the right. His gait was slow and he used a cane. Palpation of the shoulder revealed nonspecific tenderness in the left shoulder. There was moderate tenderness at the acromioclavicular joint, anterior labrum, supraspinatus, infraspinatus, bicipital group, acromion, and upper trapezius on the left. Supraspinatus resistance test was positive bilaterally. Impingement maneuver was positive on the left shoulder. Apprehension testing for anterior instability and apprehension for inferior instability reveal pain to the left shoulder. There was limited range of motion noted. Tenderness was noted with palpitation of bilateral paraspinal levels C4-5, C5-6, C6-7, and C7-T1 including radiating pain greater left than right. At levels C4-5, C5-6, C6-7, and C7-T1, palpation revealed moderate tenderness at the facet joints bilaterally, left greater than right, referring to the trapezius. Palpation revealed mild sub occipital tenderness on the right. Distraction test was positive bilaterally. Shoulder depressor test noted pain bilaterally. Foraminal compression test was positive on the right. Range of motion was limited to the cervical spine. Examination of the thoracic spine from C7 to T1, to T12 to L1 noted severe paraspinal pain upon palpation. Palpation also revealed severe tenderness at the upper trapezius bilaterally. The physician noted the injured worker used a TENS units on the mid thoracic spine to cope with pain. Range of motion to the thoracic spine was also limited. The lumbar spine presented with a positive Valsalva test bilaterally. Kemp's test/facet was positive on the right. Straight leg raise, seated test, produces pain bilaterally. Straight leg raise, supine test, was positive for pain bilaterally. Extradural involvement/sciatic tension was positive bilaterally. At levels T12 through L1, at levels L5 and S1, palpation reveals severe paraspinal muscle guarding bilaterally. Range of motion was limited in the lumbar spine. The injured worker was prescribed Norco, Nexium, and simvastatin. The physician will continue using drug urine testing. The physician will also request an open MRI without contrast of the cervical spine, as previous studies are too old. The physician will follow up with pain management consultant to rule out possible epidurals to the cervical spine and continue with pain medications. The physician will seek an MRI, a Proove narcotic test, and Norco. The rationale is Norco will help alleviate pain, the MRI will replace older diagnostic exams on file, and the Proove narcotic test will assess the injured worker's ability to utilize narcotics safely.

IMR ISSUES, DECISIONS AND RATIONALES

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

Proove narcotic test: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Genetic Testing.

Decision rationale: The Official Disability Guidelines for genetic testing for potential opioid abuse is not recommended. While there appears to be a strong genetic component to addictive behavior, current research is experimental in terms of testing for this. Studies are inconsistent, with inadequate statistics and large phenotype range. The injured worker received a Proove narcotic test on 05/08/2014 and he received a score of 18 which is a moderate score for dependence risk. The request for an additional genetic test for potential opioid abuse is not recommend by the ODG. As such, the request is not medically necessary and appropriate.

Open MRI without contrast Cervical Spine: 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 Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Magnetic Resonance Imaging.

Decision rationale: The ACOEM Guidelines note MRIs are recommended for acute neck and upper back conditions when red flags for fracture or neurologic deficit associate with acute trauma, tumor, or infection exist. The Official Disability Guidelines note repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). An open cervical MRI on 10/14/2010 noted a 2mm posterior disc protrusion at C3-4 and C5-6 with no stenosis, a 2-3mm posterior dis protrusion at C4-5 with lateral recess stenosis bilaterally, and a 4mm posterior disc protrusion with stenosis at C6-7. There have been no red flags indicating a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). There is a lack of documentation indicating the injured worker has significant objective findings of neurologic deficit. The injured worker has already received an initial MRI. As such, the request is not medically necessary and appropriate.

Norco 10/325mg #120: 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 Opioids, On-going Management Page(s): 78-79.

Decision rationale: The request for Norco 10/325 mg 120 tablets is non-certified. California MTUS Guidelines for ongoing management of opioids state prescriptions should come from a single practitioner, be taken as directed, and all prescriptions come from a single pharmacy. The

lowest possible dose should be prescribed to improve pain and function. The physician should practice the 4 A's of ongoing monitoring, which include analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The use of drug screening should be performed; if there are issues of abuse, addiction, or poor pain control inpatient treatment should be performed. The physician should document the misuse of medications and continue to review the overall situation with regard to nonopioid means of pain control. The injured worker has been utilizing Norco prior to 04/28/2014. The physician notes the injured worker is compliant with his medications. The request for 120 tablets indicates a period of greater than 3 months in conjunction with the utilization of this medication prior to 04/2014. The efficacy of this pain medication is in question, in that the injured worker continues to show no improvement in pain management or improvement in function. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request is non-certified.