

Case Number:	CM15-0171792		
Date Assigned:	09/14/2015	Date of Injury:	12/17/2009
Decision Date:	10/13/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	08/31/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 62 year old male who sustained an industrial injury on 12-17-2009. Diagnoses include cervical disc disease, cervical radiculopathy, lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and left sacroiliac joint sprain-strain. On 08-13-2015 a physician progress note documents that the injured worker has increased neck pain with bilateral upper extremity pain, numbness and tingling. He has continued lumbar spine pain with bilateral lower extremity pain, numbness and tingling. He had a fall recently and was seen in the Emergency Department. He injured his knee and had increased pain in his neck. His right knee has some swelling and it was tender to palpation over the medial and lateral joint lines and patellofemoral joint. Crepitus is present and Grind test is positive. McMurray's test elicits increased pain. A physician progress note dated 07-29-2015 documents the injured worker presents with complaints of intermittent neck and low back pain which is on and off. He rates his pain as 4-6 out of 10 which is decreased from his last visit. His neck pain is traveling to the right and left upper extremities associated with numbness and tingling that is progressively getting worse with constant headaches. His low back pain is worse than his neck pain. His low back pain is traveling to his bilateral lower extremities in the L4 and L5 distribution. He ambulates with an antalgic gait. There is tenderness to palpation with spasm and muscle guarding over the cervical paraspinal musculature and left trapezius muscle. Axial head compression and Spurling sign are positive bilaterally and there is facet tenderness to palpation of the C4-C7. Range of motion is restricted in extension and flexion. The lumbar spine has diffuse tenderness to palpation over the paraspinal musculature and there is moderate facet

tenderness to palpation over the L4-S1. Sacroiliac tenderness, Fabere's-Patrick, sacroiliac thrust test and Yeoman's test are positive on the left. Seated and supine Straight leg raise is positive on the left. Lumbar spine range of motion is restricted. Sensation is decreased in the L4, L5, and S1 dermatomes. Treatment to date has included diagnostic studies, medications, psychological treatment, physical therapy, chiropractic manipulation, and use of a Transcutaneous Electrical Nerve Stimulation unit. In a physician progress note dated 03-11-2015 there is documentation that the injured worker received epidural steroid injections on March 14, 2013 but there was no documentation of his response to these injections. Medications include Anaprox DS and Lactulose. Complete listing of current medications not found in documentation provided for review. A Magnetic Resonance Imaging of the cervical spine done on 06-03-2015 revealed C5-C6 2mm broad midline disc protrusion with mild degree of central canal narrowing and a right foraminal disc osteophyte complex with abutment of the exiting right cervical nerve root. At C6-C7 there is a 3mm broad midline and left paracentral disc protrusion resulting in abutment of the cervical cord with mild central canal narrowing. There is also a 2mm left foraminal disc protrusion with abutment of the exiting left cervical nerve root. On 06-01-2015 a Magnetic Resonance Imaging of the lumbar spine revealed L5-S1 and L4-L5 disc protrusion with resulting abutment of the descending nerve roots bilaterally as well as abutment of the exiting right and left L5 nerve roots, and exiting L4 nerve root. He is not working he is retired. The treatment plan included Right Lumbar L5-S1 (sacroiliac) Transforaminal Epidural Steroid Injection, Qty 1, Right Lumbar L4-L5 Transforaminal Epidural Steroid Injection, Qty 1, Right Cervical C5-C6 Trans facet Epidural Steroid Injection, Qty 2, Left Lumbar L5-S1 (sacroiliac) Transforaminal Epidural Steroid Injection, Qty 1, Left Lumbar L4-L5 Transforaminal Epidural Steroid Injection, Qty 1, Left Cervical C6-C7 Trans facet Epidural Steroid Injection, Qty 2, and Left Cervical C5-C6 Trans facet Epidural Steroid Injection, Qty 2. On 08-31-2015 the Utilization Review non-certified the requested treatment Urine drug screen, Qty 1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen, Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information

from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)

(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.

(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.

(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).

(g) Continuing review of overall situation with regard to nonopioid means of pain control.

(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The California MTUS does recommend urine drug screens as part of the criteria for ongoing use of opioids .The patient use of opioids was unknown at the time of request but not showing aberrant behavior and therefore the request is not medically necessary.