

Case Number:	CM15-0175148		
Date Assigned:	09/16/2015	Date of Injury:	12/27/2000
Decision Date:	10/22/2015	UR Denial Date:	08/10/2015
Priority:	Standard	Application Received:	09/04/2015

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: Florida
 Certification(s)/Specialty: Neurology, 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 62 year old female, who sustained an industrial injury on December 27, 2000. An evaluation on July 15, 2015 revealed the injured worker reported increased low back pain which she rated a 9 on a 10-point scale. She described the pain as a feeling of "contractions" to the low back. She reported left leg numbness and spasms and a cramping sensation in her calf. A previous bilateral L3-L4 and L4-L5 lumbar transforaminal epidural steroid injection on June 12, 2015 provided no relief. On physical examination, the injured worker had an antalgic gait to the left and an exacerbated left heel-toe walk. She had midline decreased cervical spine lordosis and moderate tenderness with spasm noted over the cervical paravertebral musculature and the bilateral trapezius muscles. An axial head compression of the cervical spine was positive bilaterally and a Spurling sign was positive bilaterally. She had facet tenderness to palpation over the C4-C7 spinous processes. Her cervical spine range of motion was decreased at 20 degrees on flexion, 50 degrees on extension, lateral flexion of 20 degrees bilaterally, right rotation of 60 degrees and left rotation of 70 degrees. She had normal lordosis and alignment of the lumbar spine. She had diffuse tenderness to palpation over the lumbar paraspinal muscles and moderate facet tenderness noted over the L3-S1 spinous processes. She had positive bilateral sacroiliac tenderness, positive bilateral Fabere's-Patrick test, and positive right sacroiliac thrust test. She had positive straight leg raise bilaterally and bilateral positive Kemp's test. A Farfan test was positive bilaterally. Her lumbar spine range of motion was 65 degrees on flexion, 10 degrees on extension, right lateral bending at 25 degrees and left lateral bending at 30 degrees. A urine drug screen was performed on July 15, 2015, which revealed negative results for all drugs. Her medications included Tylenol #3. The injured worker was diagnosed as having cervical disc disease, cervical radiculopathy, lumbar disc disease, lumbar radiculopathy, and lumbar facet

syndrome. Treatment to date has included physical therapy, podiatry services, lumbar transforaminal epidural steroid injection, home exercise program, and TENS unit. A request for authorization for outpatient random urine drug screen test and twelve (12) sessions of chiropractic therapy for the cervical spine and the lumbar spine was received on August 3, 2015. On August 10, 2015, the Utilization Review physician determined that outpatient random urine drug screen test and twelve (12) sessions of chiropractic therapy for the cervical spine and the lumbar spine was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy 2x a week for 6 weeks (12) sessions for the cervical and lumbar spine:
Overturned

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, and Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The medical records indicate pain related to musculoskeletal condition that has not improved with conservative treatment of surgery, medications, or PT. MTUS supports manual therapy (chiropractic treatment) as an option for up to 18 visits over 6-8 weeks with evidence of functional improvement. As such, the medical records support chiropractic care; the request is medically necessary.

Random urine drug screen test: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain, opioids, drug screen.

Decision rationale: ODG guidelines note -At the onset of treatment: (1) UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings (i.e. when opioids are required for nociceptive pain). (2) In cases in which the patient asks for a specific drug. This is particularly the case if this drug has high abuse potential, the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the patient has a positive or "at risk" addiction screen on evaluation. This may also include evidence of a history of comorbid psychiatric disorder such as depression, anxiety, bipolar disorder, and/or personality disorder. See Opioids, screening tests for risk of addiction & misuse. (4) If aberrant behavior or misuse is suspected and/or detected. See Opioids, indicators for addiction & misuse. Ongoing monitoring: (1) If a patient has evidence of a "high risk" of addiction (including evidence of a comorbid psychiatric disorder (such as depression, anxiety, attention-deficit disorder, obsessive-compulsive disorder, bipolar disorder, and/or schizophrenia), has a history of aberrant behavior, personal or family

history of substance dependence (addiction), or a personal history of sexual or physical trauma, ongoing urine drug testing is indicated as an adjunct to monitoring along with clinical exams and pill counts. See Opioids, tools for risk stratification & monitoring. (2) If dose increases are not decreasing pain and increasing function, consideration of UDT should be made to aid in evaluating medication compliance and adherence. The medical records provided for review document a formal assessment of addiction risk with report intent for chronic opioid therapy. As the medical records support these assessments, UDS is supported for current care. Therefore, the request is medically necessary.