

Case Number:	CM15-0076378		
Date Assigned:	04/28/2015	Date of Injury:	11/12/2001
Decision Date:	05/27/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/21/2015

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

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 55 year old male, who sustained an industrial injury on 11/12/01. He reported initial complaints of right shoulder, chest, and left knee pain. The injured worker was diagnosed as having cervicgia; displacement of intervertebral disc site unspecified without myelopathy; cervical root lesions NOC; carpal tunnel syndrome; spasm of muscle; status post anterior cervical disc fusion C4-C5, C5-C6 . Treatment to date has included status post rotator cuff repair (2002); status post cervical discectomy fusion C4-5 (2007) and C5-C6 (2009); physical therapy (2012); urine drug screen; medications. Diagnostics included an MRI cervical spine without contrast (7/30/13 and 3/27/15). Currently, the PR-2 notes dated 3/5/15 indicated the injured worker complains of cervical pain with bilateral upper extremity numbness. He has had a prior fusion at C4-C5 (2007) and C5-C6 (2009). An MRI of the cervical spine was completed on 3/27/15 and does not reveal any changes since the prior scan of 2013. There are no plans for additional cervical surgery at this time. He rates his pain as 8/10 with medications and is taking Norco, Flexeril and over the counter Aleve. The Lyrica was discontinued as it caused blurry vision. He is seeing another provider to evaluate his carpal tunnel syndrome/neuropathy and awaiting an EMG/NCV to be authorized. The injured worker is reported to use a cane for ambulation due to balance issues. He reports the last physical therapy was in 20012 for only a few sessions and has never has chiropractic therapy or acupuncture. The provider is requesting 3/25/15 Urine drug screen, Norco 10/325mg #90, medial nerve branch block bilateral C4-6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for Use of Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid management Page(s): 77. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Urine drug testing.

Decision rationale: The patient presents with cervical pain with bilateral upper extremity numbness. The pain is rated a 10/10 without medications and decreases to 8/10 with medications. The request is for a urine drug screen. The provided RFA is dated 03/17/15 and the date of injury is 11/12/01. The diagnoses include cervicalgia, displacement of intervertebral disc site unspecified without myelopathy, cervical root lesions NOC, carpal tunnel syndrome, spasm of muscle, status post anterior cervical disc fusion C4-C5, C5-C6. Medications include Norco, Flexeril, Naprosyn, and OTC Aleve. The patient's work status is unavailable. 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." ODG has the following criteria regarding Urine Drug Screen: "Patients at 'low risk' of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders." Per 03/05/15 report, treater states, "CURES was updated 03/04/15...urine drug screen was obtained today for safe opiate monitoring." The patient has utilized Flexeril and Norco at least since 11/11/14. Urine drug screenings were obtained on 09/14/14, 11/11/14, 01/07/15 and 03/05/15, which were all "consistent with medication management", per provided medical reports. While MTUS Guidelines do not specifically address how frequent UDS should be obtained for various risks of opiate users, ODG is more specific on the topic and recommends urine drug screens on a yearly basis if the patient is at low risk. For moderate risk, 3-4 UDS's are recommended, and for high risk as often as once per month. Furthermore, the treater has not documented that the patient is a high risk for adverse outcomes, or has active substance abuse disorder. There is no discussion regarding this patient being at risk for any aberrant behaviors. The requested urine drug screen is not medically necessary.

Norco 10/325mg, #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Hydrocodone/Acetaminophen; Opioids, criteria for use, Therapeutic Trial of Opioids, 4) On-Going Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opioids, Hydrocodone Page(s): 76-78, 88-90.

Decision rationale: The patient presents with cervical pain with bilateral upper extremity numbness. The pain is rated a 10/10 without medications and decreases to 8/10 with medications. The request is for Norco 10/325mg #90. The provided RFA is dated 03/17/15 and the date of injury is 11/12/01. The diagnoses include cervicgia, displacement of intervertebral disc site unspecified without myelopathy, cervical root lesions NOC, carpal tunnel syndrome, spasm of muscle, status post anterior cervical disc fusion C4-C5, C5-C6. Per 03/05/15 report, physical examination of the cervical spine revealed tenderness to palpation. There is decreased range of motion, with pain on flexion and extension. Foraminal closure test is positive, bilaterally. Medications include Norco, Flexeril, Naprosyn, and OTC Aleve. The patient's work status is unavailable. MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit and functioning should be measured at 6-month intervals using a numerical scale or a validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior) as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs." Norco was prescribed to the patient at least since 11/11/14, per provided medical reports. Per 03/05/15 report, treater states, "CURES was updated 03/04/15...One month supply of Norco which allows the patient to remain functional and complete his ADLs including bathing and cooking. No side effects with Norco." A urine drug screen was most recently obtained on 03/05/15 and is consistent with medications. The use of opiates requires detailed documentation regarding pain and function, per MTUS. In this case, treater has properly discussed the 4A's, as required by MTUS and therefore, the request for Norco #90 is medically necessary.

Medial nerve branch block at bilateral C4-6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back Chapter, Facet joint diagnostic blocks.

Decision rationale: The patient presents with cervical pain with bilateral upper extremity numbness. The pain is rated a 10/10 without medications and decreases to 8/10 with medications. The request is for a medial nerve branch block C4-6. The provided RFA is dated 03/17/15 and the date of injury is 11/12/01. The diagnoses include cervicgia, displacement of intervertebral disc site unspecified without myelopathy, cervical root lesions NOC, carpal tunnel syndrome, spasm of muscle, status post anterior cervical disc fusion C4-C5, C5-C6. Per 03/05/15 report, physical examination of the cervical spine revealed tenderness to palpation. There is decreased range of motion, with pain, on flexion and extension. Foraminal closure test is positive, bilaterally. MRI of the cervical spine performed on 03/27/15, revealed discectomy with

interbody fusion from C4-5, through C5-6. No canal or foraminal stenosis at these levels. 3mm broad disc osteophyte at C6-7 results in minimal canal narrowing, unchanged from prior MRI 07/30/13. Medications include Norco, Flexeril, Naprosyn, and OTC Aleve. The patient's work status is unavailable. ODG-TWC, Neck and Upper Back Chapter, under Facet joint diagnostic blocks states: "Recommended prior to facet neurotomy -a procedure that is considered "under study." Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block - MBB. Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment -including home exercise, PT and NSAIDs- prior to the procedure for at least 4-6 weeks. 4. No more than 2 joint levels are injected in one session. 8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level." For facet joint pain signs and symptoms, the ODG guidelines state that physical examination findings are generally described as: "1) axial pain, either with no radiation or severely past the shoulders; 2) tenderness to palpation in the paravertebral areas, over the facet region; 3) decreased range of motion, particularly with extension and rotation; and 4) absence of radicular and/or neurologic findings." Per 03/05/15 report, treater states, "He is tender along the midline of the cervical facets and has positive facet loading on exam. He has failed more conservative care, including physical therapy, activity modification and NSAIDs. Please consider a bilateral C4, C5, C6 MNBB for diagnostic purposes as a precursor to a potential rhizotomy to decrease pain, increase function and decrease dependency on oral medications." Given the patient's exam findings including tenderness over the facet joints with non-radicular pain, a medial branch block would appear appropriate. However, ODG states, "Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the p lanned injection level." In this case, the patient has a history of a C4-C5, C5-C6 fusion. The request is not within guidelines and therefore, is not medically necessary.