

<b>Case Number:</b>	CM15-0095057		
<b>Date Assigned:</b>	05/21/2015	<b>Date of Injury:</b>	06/30/1992
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	04/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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 62-year-old male who sustained an industrial injury on 6/30/92. The injured worker was diagnosed as having status post multiple traumas, cervical spine degeneration/herniation, status post cervical anterior arthrodesis and instrumentation, left shoulder impingement syndrome, lumbar disc herniation, status post right knee arthroscopic knee surgery and status post open reduction and internal fixation of the left tibia. Currently, the injured worker was with complaints of pain in the neck, left shoulder, left wrist, left hand, lower back and left foot and ankle. Previous treatments included multiple surgical interventions, medication management, activity modification, physical therapy and home exercise program. Physical examination was notable for cervical spine hypoesthesia at C5-C6 and C6-C7 bilaterally, left shoulder with tenderness and subacromial grinding and clicking, hypoesthesia noted at the anterolateral aspect of foot and ankle and right knee with medial joint line tenderness. The plan of care was for an epidural injection, laboratory studies and a urine drug screen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Urinalysis (Urine Drug Screen):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Preoperative lab testing, General Preoperative Testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter, under Urine Drug Testing.

**Decision rationale:** The patient presents on 03/19/15 with unrated pain in the neck, left shoulder, left wrist, left hand, lower back, and left foot/ankle. The patient's date of injury is 06/30/92. Patient is status post cervical anterior arthrodesis and instrumentation complicated with cephalgia, hardware removal, and Brown-Seguard syndrome. The patient also has a history of right knee arthroscopic surgery in 2007, and open reduction and fixation of the left tibia. The request is for URINALYSIS. The RFA was not provided. Physical examination dated 03/18/15 reveals a healed surgical incision from the anterior cervical arthrodesis, and hyposthesia in the C5 through C7 dermatome distributions bilaterally. Left shoulder examination reveals tenderness to palpation over the greater tuberosity of the humerus with subacromial grinding and clicking noted. Left hand examination reveals positive Tinel's sign, Phalen's sign, and abnormal two-point discrimination greater than 8mm. Lumbar spine examination reveals positive straight leg raise test bilaterally, hypoesthesia at the anterolateral aspect of the foot and ankle of an incomplete nature along the L5-S1 dermatomal distribution. Right knee examination reveals well-healed surgical incisions, and medial joint line tenderness with positive chondromalacia with compression. The patient is currently prescribed Percocet, Ativan, Morphine, and Linzess stool softener. Diagnostic imaging was not included. Patient is currently classified as permanent and stationary. While MTUS Guidelines do not specifically address how frequent UDS should be considered for various risks of opiate users, ODG Pain Chapter, under Urine Drug Testing has the following: "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." In this case, the provider is requesting a UDS to ensure that this patient is compliant with his narcotic medications. There is no evidence in the records if this patient has had any urine drug screens to date; this patient is currently prescribed Percocet and Morphine. ODG supports the use of annual drug screenings to ensure patient compliance with Narcotic medications. As there is no evidence in the records if this patient has undergone any screenings to date, such a screening is substantiated. The request IS medically necessary.

**Preoperative labs: Complete blood count, Chem 7: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Preoperative lab testing, General Preoperative Testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, Preoperative lab testing.

**Decision rationale:** The patient presents on 03/19/15 with unrated pain in the neck, left shoulder, left wrist, left hand, lower back, and left foot/ankle. The patient's date of injury is 06/30/92. Patient is status post cervical anterior arthrodesis and instrumentation complicated with cephalgia, hardware removal, and Brown-Seguard syndrome. The patient also has a history of right knee arthroscopic surgery in 2007, and open reduction and fixation of the left tibia. The request is for PRE-OPERATIVE LABORATORY WORK-UP (COMPLETE BLOOD COUNT AND CHEM 7). The RFA was not provided. Physical examination dated 03/18/15 reveals a healed surgical incision from the anterior cervical arthrodesis, and hypostheia in the C5 through C7 dermatome distributions bilaterally. Left shoulder examination reveals tenderness to palpation over the greater tuberosity of the humerus with subacromial grinding and clicking noted. Left hand examination reveals positive Tinel's sign, Phalen's sign, and abnormal two-point discrimination greater than 8mm. Lumbar spine examination reveals positive straight leg raise test bilaterally, hypoesthesia at the anterolateral aspect of the foot and ankle of an incomplete nature along the L5-S1 dermatomal distribution. Right knee examination reveals well-healed surgical incisions, and medial joint line tenderness with positive chondromalacia with compression. The patient is currently prescribed Percocet, Ativan, Morphine, and Linzess stool softener. Diagnostic imaging was not included. Patient is currently classified as permanent and stationary. While ODG head and neck chapter does not discuss Preoperative lab testing, The Low Back - Lumbar & Thoracic Chapter has the following: "Recommended as indicated below. Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach. Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. Criteria for Preoperative lab testing: Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material; Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure; Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus; In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management; A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated; Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants." In regard to the preoperative blood labs, presumably to identify potential risk factors, the provider has not specified a reason for the request. While this patient presents with a significant surgical history with complications noted, the documentation provided does not indicate that this patient is anticipating any surgeries. The only procedure that could be considered surgical in nature is the associated request for a cervical ESI, which is not supported owing to a lack of imaging corroborating spinal stenosis. Without evidence of upcoming surgeries or a clear rationale as to why such testing is required, this request cannot be substantiated. The request IS NOT medically necessary.

**Preoperative labs: Partial Thromboplastin Time, Prothrombin Time/International Normalized Ratio: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Preoperative lab testing, General Preoperative Testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, Preoperative lab testing.

**Decision rationale:** The patient presents on 03/19/15 with unrated pain in the neck, left shoulder, left wrist, left hand, lower back, and left foot/ankle. The patient's date of injury is 06/30/92. Patient is status post cervical anterior arthrodesis and instrumentation complicated with cephalgia, hardware removal, and Brown-Seguard syndrome. The patient also has a history of right knee arthroscopic surgery in 2007, and open reduction and fixation of the left tibia. The request is for PRE-OPERATIVE LABORATORY WORK-UP (PARTIAL THROMBOPLASTIN TIME, PROTHROMBIN TIME/INTERNATIONAL NORMALIZED RATIO). The RFA was not provided. Physical examination dated 03/18/15 reveals a healed surgical incision from the anterior cervical arthrodesis, and hypostheia in the C5 through C7 dermatome distributions bilaterally. Left shoulder examination reveals tenderness to palpation over the greater tuberosity of the humerus with subacromial grinding and clicking noted. Left hand examination reveals positive Tinel's sign, Phalen's sign, and abnormal two-point discrimination greater than 8mm. Lumbar spine examination reveals positive straight leg raise test bilaterally, hypoesthesia at the anterolateral aspect of the foot and ankle of an incomplete nature along the L5-S1 dermatomal distribution. Right knee examination reveals well-healed surgical incisions, and medial joint line tenderness with positive chondromalacia with compression. The patient is currently prescribed Percocet, Ativan, Morphine, and Linzess stool softener. Diagnostic imaging was not included. Patient is currently classified as permanent and stationary. While ODG head and neck chapter does not discuss Preoperative lab testing, The Low Back - Lumbar & Thoracic Chapter has the following: "Recommended as indicated below. Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach. Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. Criteria for Preoperative lab testing: Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material; Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure; Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus; In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management; A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom

significant perioperative blood loss is anticipated; Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants." In regard to the preoperative blood labs, presumably to identify potential risk factors, the provider has not specified a reason for the request. While this patient presents with a significant surgical history with complications noted, the documentation provided does not indicate that this patient is anticipating any surgeries. The only procedure, which could be considered surgical in nature, is the associated request for a cervical ESI, which is not supported owing to a lack of imaging corroborating spinal stenosis. Without evidence of upcoming surgeries or a clear rationale as to why such testing is required, this request cannot be substantiated. The request IS NOT medically necessary.

### **1 Cervical epidural injection (unspecified level(s)): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

**Decision rationale:** The patient presents on 03/19/15 with unrated pain in the neck, left shoulder, left wrist, left hand, lower back, and left foot/ankle. The patient's date of injury is 06/30/92. Patient is status post cervical anterior arthrodesis and instrumentation complicated with cephalgia, hardware removal, and Brown-Segard syndrome. The patient also has a history of right knee arthroscopic surgery in 2007, and open reduction and fixation of the left tibia. The request is for 1 CERVICAL EPIDURAL STEROID INJECTION. The RFA was not provided. Physical examination dated 03/18/15 reveals a healed surgical incision from the anterior cervical arthrodesis, and hypostheia in the C5 through C7 dermatome distributions bilaterally. Left shoulder examination reveals tenderness to palpation over the greater tuberosity of the humerus with subacromial grinding and clicking noted. Left hand examination reveals positive Tinel's sign, Phalen's sign, and abnormal two-point discrimination greater than 8mm. Lumbar spine examination reveals positive straight leg raise test bilaterally, hypoesthesia at the anterolateral aspect of the foot and ankle of an incomplete nature along the L5-S1 dermatomal distribution. Right knee examination reveals well-healed surgical incisions, and medial joint line tenderness with positive chondromalacia with compression. The patient is currently prescribed Percocet, Ativan, Morphine, and Linzess stool softener. Diagnostic imaging was not included. Patient is currently classified as permanent and stationary. MTUS has the following regarding ESI's, under its chronic pain section: Page 46, 47: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support "series-of-three" injections in either the diagnostic or the therapeutic phase. We recommend no more than 2 ESI injections." In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. MTUS states on p46, "There is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." In this

case, the provider is requesting a cervical ESI targeted at an unspecified level. Progress note dated 03/18/15 includes documentation of radicular pain and hypoesthesia in the upper extremities along the C5 to C7 dermatomal distributions. However, a careful review of the documentation provided does not include any imaging studies corroborating stenosis in the cervical spine. Additionally, MTUS guidelines state that there is insufficient evidence of the efficacy of cervical ESI to treat cervical radicular pain. Therefore, the request IS NOT medically necessary.