MAXIMUS Federal Services

| Case Number: | CM13-0018041 | | |
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| Date Assigned: | 10/11/2013 | Date of Injury: | 04/28/2005 |
| Decision Date: | 02/07/2014 | UR Denial Date: | 08/22/2013 |
| Priority: | Standard | Application Received: | 08/29/2013 |

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology and Pain Management and is licensed to practice in Georgia. 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 physician 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 claimant is a 49-year-old female presenting with back pain following a work-related injury on 4/28/2005. The claimant complains of severe back pain that radiates to the right foot left thigh and right thigh. The pain is described as a deep, ache that is discomforting, piercing, sharp, shooting, stabbing and throbbing. The pain is rated as 10 out of 10 without medication and a 4-10 with medications. The physical exam was significant for bilateral tenderness of the lumbar paraspinous muscles, limited lumbar spine range of motion, positive modified gaenslen test. MRI of the lumbar spine showed postsurgical changes at L4-5, degenerative disc disease at L4-5 and L5-S1, postoperative scarring in the anterior epidural space at L4-5, and slight narrowing of the neuro foraminal bilaterally at L4-5. MRI of the left hip was significant for a millimeter well-circumscribed, nodular subchondral 12 marrow hyper intensity of the inferior left femoral head as a nonspecific finding. The claimant had bilateral sacroiliac joint injections under fluoroscopy with conscious sedation. The claimant reported 75% reduction in her pain. The claimant was diagnosed with chronic pain syndrome, spinal stenosis of the lumbar region, low back pain, failed back surgery, myalgia, facet arthropathy, and sacroiliitis. The release medications include Requip, oxycodone 15mg, naproxen, Lunesta, and baclofen. The claimant has requested authorization for the right side lumbosacral facet injection at L4-5 and L5-S1, Requip, Prilosec, and IV sedation.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right side lumbosacral facet joint injection at L4-5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Seghal, Nalini et al. Systematic Review of Diagnostic Utility of Facet (Zygapophysial) Joint Injections In Chronic Spinal Pain: An Update. Pain Physician. 2007; 10: 213-228

**Decision rationale:** Lumbar facet injection at L4-5 in this case is not medically necessary MTUS references the Occupation medicine practice guidelines on page 300 which states that "Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks." Additionally, The Occupation medicine practice guidelines criteria for use of diagnostic facet blocks require that the clinical presentation be consistent with facet pain. Treatment is also limited to patients with low back pain that is nonradicular and had no more than 2 levels bilaterally documentation of failed conservative therapy including home exercise physical therapy and NSAID is required prior to the diagnostic facet block. The medical records do not document that there was a failure of conservative therapy. Additionally the physical exam does not show evidence of facet joint pathology including pain with facet loading. Lumbar facet injection at L4-5 is therefore not medically necessary. The medical literature also falls in line with the rationale for this case. Seghal et al. (Pain Physician, 2007) performed a 2-year literature review from 2004-2006 to update current scientific evidence on diagnostic utility of facet joint injections. They reported that diagnostic injections are employed to diagnose facet joint pain because available techniques cannot identify the pain generators in patients with chronic spinal pain; however, facet joint injections are used to determine if pain is arising from these joints, distinguishing painful from non-painful joints and prognosticating response to therapeutic facet joint interventions.

**Right side lumbosacral facet injection at L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 300. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Seghal, Nalini et al. Systematic Review of Diagnostic Utility of Facet (Zygapophysial) Joint Injections In Chronic Spinal Pain: An Update. Pain Physician. 2007; 10: 213-228

**Decision rationale:** Lumbar facet injection at L5-S1 in this case is not medically necessary MTUS references the Occupation medicine practice guidelines on page 300 which states that "Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks." Additionally, The Occupation medicine practice guidelines criteria for use of diagnostic facet blocks require that the clinical presentation be consistent with facet pain. Treatment is also limited to patients with low back pain that is nonradicular and had

no more than 2 levels bilaterally documentation of failed conservative therapy including home exercise physical therapy and NSAID is required prior to the diagnostic facet block. The medical records do not document that there was a failure of conservative therapy. Additionally the physical exam does not show evidence of facet joint pathology including pain with facet loading. Lumbar facet injection at L5-S1 is therefore not medically necessary.

**Requip 1mg, #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Cheer, Susan M. Ropinirole, CNS Drugs, 2004; 18(11):747-754

**Decision rationale:** Requip is Ropinirole. CA MTUS and ODG does not make a statement on this medication. According to the Drug compendiums (CNS Drugs, 2004) Ropinirole is indicated for restless leg syndrome. Ropinirole did not seem to be more superior to opioids in relieving restless leg syndrome. Ropinirole is a non-ergoline dopamine agonist that exhibits a high affinity for D2 and D3 receptors but little or no affinity for D1-like and non-dopaminergic receptors. Symptoms of restless legs syndrome (RLS) [measured using the International Restless Legs scale and Clinical Global Impression-Global Improvement Scale scores] significantly improved with ropinirole compared with placebo in large, randomized, double-blind trials. Ropinirole reduced periodic leg movements and improved sleep efficiency relative to baseline and placebo in several trials (two of which were randomized, double-blind and relatively large) in patients with RLS. Ropinirole was generally well tolerated in patients with RLS; adverse events were generally mild to moderate in nature and consistent with those expected of dopamine agonists. Few patients receiving ropinirole withdrew from therapy because of adverse events, the most predominant of which were nausea and headache. As it refers to this case. There was not a well documented indication for the reason why Requip was prescribed. Additionally, if it were prescribed for restless leg syndrome, the claimant is already on an opioid in which the medical literature reports are just as effective in treating RLS as requip. Requip is therefore not medically necessary.

**Prilosec 20mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs,SSRIs Page(s): 69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

**Decision rationale:** Prilosec 20 mg # 60 is not medically necessary. CA MTUS does not make a direct statement on proton pump inhibitors (PPI) but in the section on NSAID use page 67. Long term use of PPI or misoprostol or Cox-2 selective agents has been shown to increase the risk of Hip fractures. CA MTUS does state that NSAIDs are not recommended for long term use as well

and if there possible GI effects of another line of agent should be used for example acetaminophen. Prilosec is therefore, not medically necessary.

**IV sedation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.