

Case Number:	CM14-0002592		
Date Assigned:	01/24/2014	Date of Injury:	10/17/2006
Decision Date:	06/19/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	01/07/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/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 patient is an employee of [REDACTED] and has submitted a request for post laminectomy syndrome of the lumbar region, and lumbar disc disorder with myelopathy associated with an industrial injury date of October 17, 2006. The treatment to date has included back surgeries x 7 (fusion followed by a donor disc from an anterior approach, among others), facet block, epidural injection, chiropractic care, and medications such as IM Toradol and Vitamin B injection, Detrol, nortriptyline, and Percocet. Medical records from 2013 were reviewed showing that patient complained of 75% low back pain, rated 8 to 9/10 and 25% in the right hip described as dull and aching. It was exacerbated by sitting, standing, and lifting and relieved with medication intake. The patient did not report of any new profound weakness or instability. Physical examination revealed a surgical scar over the lumbar area. Range of motion of the lumbar spine was restricted to 15 degrees of extension, and 30 degrees of rotation to the right with presence of pain. Lumbar facet loading was positive on both sides. FABER test was positive. Ankle jerk was 1/4 bilaterally while patellar jerk was absent. Motor strength of right extensor hallucis longus was graded 4 to 5/5. Sensation was decreased at the right lateral calf. The utilization review from December 11, 2013 denied the requests for x-ray of the bilateral sacroiliac joints, bilateral hips, and flexion/extension views of the lumbar spine because there was noted spinal instability or evidence of a new injury, bilateral L4 and L5 MBB because it has been done in the past which resulted to pain relief for 5 days only, Percocet 10/325mg, #180 due to lack of evidence of pain relief or functional gains and IM injection of Toradol 30 mg because this is not indicated for chronic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL ON L4 AND L5 MBB: 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 Official Disability Guidelines (ODG) Low Back Chapter, Medial Branch Block.

Decision rationale: The California MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG) was used instead. It states that medial branch blocks (MBB) are not recommended for treatment except as a diagnostic tool for patients with non-radicular low back pain limited to no more than two levels bilaterally. In this case, the request does not specify if the MBB is intended as a diagnostic or therapeutic procedure. MBBs are not recommended as treatment due to minimal evidence for efficacy. Facet block of unspecified levels was done in 2012 resulting to more than 50% improvement for 5 days. There is no discussion regarding indication for a repeat MBB even if it only provided pain relief for a limited period of time. Furthermore, ODG states that facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. Medical records submitted and reviewed indicate that the patient underwent lumbar fusion surgery, however, the exact level of fusion was not documented. For the above reasons, the guideline criteria were not met. Therefore the request for bilateral on L4 and L5 MBB is not medically necessary.

X-RAY OF THE BILATERAL SI JOINTS, BILATERAL HIPS, AND FLEXION/EXTENSION VIEWS OF THE LUMBAR SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Section, X-ray.

Decision rationale: The California MTUS ACOEM states that lumbar spine X-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. On the other hand, X-Rays of the pelvis should routinely be obtained in patients sustaining a severe injury, or hip osteoarthritis. There are limitations of radiography in detecting hip or pelvic pathologic findings, including fractures, as well as soft-tissue pathologic findings. In this case, the rationale indicated for this request is due to greater coccyx and right buttock pain. X-rays of the hip and lumbar spine were accomplished in 2012, however, results were not available for review. Moreover, the objective

findings presented do not support worsening of symptoms that may warrant additional radiographic imaging. It is unclear what specific etiology is being considered requiring X-rays as diagnostic procedure, and how it will affect treatment plans. There is no evidence of new injuries that support utilization of X-rays. Therefore, the request for x-ray of the bilateral SI joints, bilateral hips, and flexion/extension views of the lumbar spine is not medically necessary.

PERCOCET 10/325MG #180 WITH 3 REFILLS: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: Page 78 of California MTUS Chronic Pain Medical Treatment Guidelines states that there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related 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. In this case, the exact date of initial intake of opioid is not documented. Percocet is being prescribed for breakthrough pain. Medical records submitted and reviewed indicate that Percocet relieves the pain and without it, the patient could not function and get out of bed. She noted that opioid intake is significant in assisting her with activities of daily living as she has 4 children to care for. There is likewise no adverse effects and aberrant drug-related behaviors noted. The guideline criteria for precise documentation of chronic opioid use have been met. Therefore, the request for Percocet 10/325mg #180 with 3 refills is medically necessary.

ONE IM INJECTION OF TORADOL 30MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Ketorolac (Toradol).

Decision rationale: As stated on page 72 of California MTUS Chronic Pain Medical Treatment Guidelines, Ketorolac (Toradol) is not indicated for minor or chronic painful conditions. ODG Pain Chapter further states that Ketorolac, when administered intramuscularly, may be used as an alternative to opioid therapy. In this case, the patient has been taking Oxycodone/APAP (Percocet) at the time when he received Toradol injection in 2013, thus this was prescribed not as an alternative medication, but rather, as an adjunct to treatment which is not recommended by the guidelines. Moreover, medical records submitted and reviewed do not include evidence of a decrease in pain score or any functional improvement attributed to Toradol use. Lastly, the patient has chronic low back and right hip pain; however, Ketorolac is not indicated for chronic

painful disorders as stated above. The guideline criteria have not been met. Therefore, the request for one IM injection of Toradol 30mg is not medically necessary.