

Case Number:	CM14-0008917		
Date Assigned:	02/14/2014	Date of Injury:	10/06/2011
Decision Date:	07/11/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/23/2014

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 a 40-year-old female who has filed a claim for lumbar and cervical facet joint arthropathy associated with an industrial injury date of October 06, 2011. Review of progress notes indicates increased low back pain radiating to the buttocks. Patient also has neck pain radiating to the left upper extremity. Findings include tenderness of the cervical and lumbar regions, decreased cervical and lumbar range of motion due to pain, mildly positive cervical and lumbar discogenic maneuvers, decreased motor strength of the left deltoid, and decreased sensation in the left C6 dermatome. Treatment to date has included NSAIDs (non-steroidal anti-inflammatory drugs), muscle relaxants, gabapentin, sedatives, anti-depressants, opioids, cervical and lumbar epidural steroid injections. Utilization review from January 16, 2014 denied the requests for fluoroscopically guided bilaterally L4-5 and L5-S1 facet joint medial branch block as it is not recommended in the presence of radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLUOROSCOPICALLY-GUIDED BILATERAL L4-L5 AND L5-S1 FACET JOINT MEDIAL BRANCH BLOCK: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Facet Joint Medial Branch Blocks (Therapeutic Injections) and Facet Joint Diagnostic Blocks (Injections).

Decision rationale: According to the Low Back Complaints Chapter of the ACOEM Practice Guidelines, facet injections are recommended for non-radicular facet mediated pain. In addition, ODG criteria for facet injections include documentation of low-back pain that is non-radicular, failure of conservative treatment prior to the procedure for at least four to six weeks, no more than two joint levels to be injected in one session, and evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint therapy. In this case, patient presents with findings suggestive of lumbar radiculopathy, which does not meet the indications for facet joint injections. Also, according to the ODG, medial branch blocks are not recommended except as a diagnostic tool for patients with non-radicular low back pain limited to no more than two levels bilaterally, with conservative treatment prior to the procedure for at least four to six weeks. They should not be performed in patients who have had a previous fusion procedure at the planned injection level, and no more than 2 joint levels should be injected in one session. In this case, patient presents with cervical and lumbar radiculopathy. The request for a fluoroscopically-guided bilateral L4-L5 and L5-S1 facet joint medial branch block is not medically necessary or appropriate.

OXYCODONE, 10MG THREE TIMES DAILY AS NEEDED: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 110.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; On-Going Management Page(s): 78-82.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since at least October 2013. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Previous utilization review determination, dated January 16, 2014, has already certified this request. The request for Oxycodone 10 mg is not medically necessary or appropriate.

RELAFEN 500 MG 1 TAB BY MOUTH TWICE DAILY #60 WITH 4 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS) Page(s): 102.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (nonsteroidal anti-inflammatory drugs) Page(s): 67-69.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. Patient has been on this medication since October 2013. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Previous utilization review determination, dated January 16, 2014, has already certified this request. The request for relafen 500 mg 1 tab by mouth twice daily, sixty count with four refills, is not medically necessary or appropriate.