

Case Number:	CM14-0151377		
Date Assigned:	09/19/2014	Date of Injury:	07/10/2009
Decision Date:	10/22/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/16/2014

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 claimant injured his low back on 07/10/09. Percocet and left side radiofrequency ablation are under review. The claimant has a diagnosis of a low back injury. He was descending the stairs of a transportation bus, took a wide step and came down and had immediate onset of low back pain. He is dependent on opioids and has been taking Percocet. He was injured in approximately the same way on 2 different occasions. He returned to work and was evaluated on 08/28/09. He still had limitations in his activities. He had tried physical therapy in the past and was taking narcotics for pain. He had an MRI on 08/23/10 and had multilevel degenerative abnormalities that were stable with no evidence of progression. He had a right medial branch block on 02/03/14. On 02/20/14, he reported left-sided back pain and knee pain and was awaiting a total knee replacement. Medications included morphine and Flexeril. He had no focal neurologic deficits and the examination generally was unremarkable. He was diagnosed with sacroiliac sprain, lumbar DDD, and facet arthropathy. He was given Morphine for breakthrough pain and left-sided L3, 4, and 5 radiofrequency ablations were recommended. He had radiofrequency 6 months before and his functional level had improved. He was able to swim one mile per day and also had lost weight. He was taking Morphine and Flexeril. On 02/28/14, the provider stated that he had 60% pain relief with RFA in the past. He switched from Norco to morphine due to a rash. On 03/20/14, he reportedly had 50% pain relief from a previous injection on 09/10/13. He was scheduled for left L3-5 radiofrequency ablation on 03/31/14. He had previously failed a right side medial branch nerve block and lumbar ESI. He had increased muscle aching with MSIR and was prescribed Norco and Flexeril. He reported greater than 50% relief of his pain with an injection back on 09/10/13. He underwent left lumbar medial branch RFA with sedation on 03/31/14. On 04/17/14, he reported feeling better and he was going to go on vacation. His pain was down about 50%. He was willing to decrease the Norco. Physical

findings were unchanged and he was given Soma. On 05/15/14, he reported 50% pain relief after the RFA but it only lasted one month. He had continued relief of his left lower extremity radiculitis. He was getting 30-40% relief of his pain with Norco maximum 6 per day for his chronic pain. It allowed him to row a rowboat for 2 hours and swim one mile 3 times weekly. He was starting yoga. He is morbidly obese and had a slow gait and decreased range of motion of his back. There were no focal neurologic deficits. He was a possible surgical candidate. On 06/12/14, he reported being better since the radiofrequency ablation. His leg pain decreased more than the back pain. He did not want surgery. His pain was 5/10 without his pain medication and he was using Soma for muscle spasms. He also had bilateral knee pain. On 07/10/14, he reported that medications and yoga significantly reduced his chronic pain. He was taking Norco 6 per day which was a stable dose. He is 6 foot 7 inches and 350 pounds. He had decreased range of motion of the right knee and ankle. His pain level was 5-6/10. On 08/07/14, he reported that he had returned from a diving trip and he had increased pain and ongoing left lower extremity numbness. He had greater than 50% relief from the lumbar ESI that lasted only 2 days. He was awaiting right ankle surgery. He was still on the same dose of Norco. Soma was being paid for out of pocket. His physical examination was unchanged. On 09/04/14, he reported decreased efficacy of Norco during extreme flareups of pain. He had been working on his vacation home which had flood damage. He wanted a second medication for extreme flareups. He was switched from Norco max 6 per day to Percocet max 6 per day. His pain level was 8-9/10.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 mg Quantity: 180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain Page(s): 110.

Decision rationale: The history and documentation do not objectively support the request for the opioid, Percocet 10/25 mg #180. The MTUS outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as Acetaminophen or nonsteroidal anti-inflammatory drugs. MTUS further explains, "pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." There is also no indication that periodic monitoring of the claimant's pattern of use and a response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that he has been involved in an ongoing rehab program to help maintain any benefits he receives from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and

aberrant drug-taking behaviors" should be followed and documented per the guidelines. The claimant's pattern of use of Percocet is unclear other than he takes it. There is no evidence that a signed pain agreement is on file at the provider's office and no evidence that a pain diary has been recommended. In addition, the results of periodic drug screens have not been submitted with this file. As such, the medical necessity of the use of Percocet 10/325 mg #180 has not been clearly demonstrated.

Left radiofrequency ablation L3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Chapter

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, Radiofrequency Ablation.

Decision rationale: The history and documentation do not objectively support the request for repeat left L3 radiofrequency ablation. The ODG state radiofrequency ablation is "under study. Criteria for use of facet joint radiofrequency neurotomy:(1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections).(2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. (3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. (4) No more than two joint levels are to be performed at one time.(5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy."The ODG further state "Criteria for the use of diagnostic blocks for facet "mediated" 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 last at least 2 hours for Lidocaine.2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally...."In this case, the claimant underwent left side radiofrequency ablation that gave him about 50% relief but it only lasted one month. The ODG recommend repeat RFA only if pain relief lasts at least six months. A repeat left radiofrequency ablation, therefore, is not supported as medically necessary.