

Case Number:	CM14-0034418		
Date Assigned:	06/23/2014	Date of Injury:	09/10/2003
Decision Date:	07/24/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/19/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, 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:

This is a male patient with the date of injury of September 10, 2003. An Orthopedic Spine Surgery Narrative Progress Report dated February 27, 2014 identifies Present Complaints of daily and constant ongoing low back pain, bilateral leg pain, and sleep difficulty secondary to pain. Facet blocks improved his back pain by approximately 70%. Physical Examination identifies palpable tenderness of the SI joints and upper buttocks bilaterally. Sensation decreased over the left L4 dermatome distribution. Decreased lumbar range of motion. Positive facet loading. Left hip flexion strength 4/5. Assessment identifies L4-S1 disc degeneration/facet arthropathy, right distal radius fracture, healed, with intermittent chronic pain, and bilateral lumbar radiculopathy. Discussion identifies facet blocks were diagnostic, request authorization for radiofrequency ablation at the L4-S1 levels. Prescription for Medrol Dose Pack and Percocet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 mg, 240 count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (MTUS), 2009; Chronic Pain Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (EFFECTIVE JULY 18, 2009) Page(s): 76-79, 120 OF 127.

Decision rationale: Regarding the request for Percocet (oxycodone/acetaminophen), California Pain Medical Treatment Guidelines state that Percocet is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the Percocet is improving the patient's function or pain (in terms of percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. The request for Percocet 10/325 mg, 240 count, is not medically necessary or appropriate.

Medrol - Dose Pack, quantity of one: 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) Treatment Index 12th Edition (web), 2014 Low Back, Corticosteroids.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), LOW BACK CHAPTER, CORTICOSTEROIDS (ORAL/PARENTERAL/IM FOR LOW BACK PAIN).

Decision rationale: Regarding the request for Medrol - Dose Pak, Occupational Medicine Practice Guidelines state oral corticosteroids are not recommended for low back pain. ODG states oral corticosteroids are recommended in limited circumstances for acute radicular pain. Within the documentation available for review, the patient is noted to have chronic radicular pain. Guidelines support oral corticosteroids for acute radicular pain, which is not the case here. Therefore, the request for Medrol - Dose Pack, quantity of one is not medically necessary or appropriate.

Radio frequency ablation (RFA) to the L4 - S1 levels: 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), Treatment Index, 12th Edition(web), 2014, Low Back, Facet Joint radiofrequency neurotomy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER, FACET JOINT PAIN, SIGNS & SYMPTOMS, FACET JOINT DIAGNOSTIC BLOCKS (INJECTIONS), FACET JOINT RADIOFREQUENCY NEUROTOMY.

Decision rationale: Regarding the request for radiofrequency ablation to the L4-S1 levels, the Chronic Pain Medical Treatment Guidelines state there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same

procedure in the lumbar region. 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. ODG states the 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. 3. There is documentation of failure of conservative treatment (including home exercise, PT [physical therapy] and NSAIDs [non-steroidal anti-inflammatory drugs]) prior to the procedure for at least four to six weeks. ODG further recommends the following 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. Within the documentation available for review, there is documentation that the clinical presentation is consistent with facet joint pain, signs & symptoms, and 70% improvement of low back pain with the branch blocks was documented. However, the Guidelines state these procedures are limited to patients with low-back pain that is non-radicular. The patient is noted to have radiating pain and decreased sensation over the left L4 dermatome distribution. The request for radio frequency ablation (RFA) to the L4 - S1 levels is not medically necessary or appropriate.