

Case Number:	CM14-0203603		
Date Assigned:	12/16/2014	Date of Injury:	09/08/1984
Decision Date:	02/04/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/05/2014

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 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 injured worker is a 61 year-old male with a date of injury of September 8, 1984. The patient's industrially related diagnoses include lumbago, facet arthropathy, and lumbar radiculopathy. The injured worker underwent L2-L5 decompression in 2000, L1-L5 decompression in 2008, and L2-L5 laminectomy in 2012. The injured worker had facet blocks at L5-S1 in 6/2014 and L4-5 facet block in 11/2014 that did not significantly improve pain. The injured worker had bilateral L4 and L5 medial branch block on 11/3/2014 with reported 60-70% relief for 4-5 hours after the injections. The disputed issues are Methadone 10mg, lumbosacral medial branch radiofrequency ablation, adjustable queen size bed with separate controls, and physical therapy evaluation plus 12 sessions for low back pain. A utilization review determination on 11/24/2014 had non-certified these requests. The stated rationale for the denial of Methadone was: "Evidence based guidelines stated that the patient should receive a screen for the risk of addiction including such questions as: Is there likelihood of abuse or an adverse outcome? Specific questions about current use of alcohol, illegal drugs, other prescription drugs, and over-the-counter drugs should be asked. In this case the answer is positive indicating red flags for prescription of opioids. The patient has apparently failed to achieve any pain relief with substantial amounts of Percocet. It is not apparent that increasing the medication will be successful in controlling the patient's pain. The patient has exhibited dose escalation with Percocet on the patient's own which would be particular dangerous with methadone which has a lag in the temporal relationship of pain control to rising blood levels. Methadone is particular dangerous when prescribed in an as needed manner as is documented here. As per the documentation received the medical necessity for the request for Methadone HCL 10mg is not established." The stated rationale for the denial of lumbosacral medial branch radiofrequency was: "In this case, the patient was diagnosed with lumbago and lumbar radiculopathy. The

patient had a lumbar facet injection approximately 10/2014 with temporary relief and had an injection approximately in 11/2014 for emergency pain relief. The patient also had left sided block and bilateral L4-5 medial branch block on 11/3/2014. The patient had significant left-sided back and leg pain, decreased sensation along the left thigh, decreased extensor function of the left foot, significant antalgia and urinary symptoms. The patient had initial relief with surgery and nerve block. LumboSacral medial branch radiofrecqncy was being requested. However, as per the medicals available for this review the criteria #1, 2, 3, 4, and 6 are not met. The medical necessity for this request is not established." The stated rationale for the denial of the adjustable queen sized bed was: "As per the medicals, neither of these conditions is met in this case and therefore medical necessity for the request is not established." Lastly, the stated rationale for the denial of physical therapy was: "The patient's functional goals of this current request for therapy are not articulated or apparent. The patient's progress in last most recent physical therapy sessions is not provided and the medical necessity for this request is not established."

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone HCL 10 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61-62, 75-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Methadone

Decision rationale: Regarding the request for methadone, Chronic Pain Medical Treatment Guidelines state methadone is recommended as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk. Due the variable half-life and short lasting pain relief of Methadone, the ODG guidelines state that vigilance is suggested in treatment initiation, conversion from another opioid to methadone, and when titrating the methadone dose. Close monitoring of patients who receive methadone is recommended, especially during treatment initiation. The patient should be informed that methadone is not a breakthrough medication and the patient should not be tempted to take more methadone than prescribed if they are not getting pain relief as this can lead to a dangerous build-up that can lead to death. Furthermore, patients should be informed of arrhythmia risk when prescribed methadone. Within the documentation available for review, methadone was prescribed to be taken every 4-6 hours as needed for severe pain. The documentation identified that methadone was prescribed as a second-line drug to replace Percocet since the injured worker had increased his use of the Percocet 10-325mg to 7/day. However, there was no discussion of how the potential benefits of Methadone use outweigh the risks in this case and no documentation that cardiac risks were discussed. Furthermore, the guidelines do not recommended the use of Methadone on an as needed basis as the prescription was written. In light of these issues, the currently requested methadone 10 mg is not medically necessary.

LumboSacral Medial Branch Radiofrequency Ablation: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Facet Joint Pain, Signs and Symptoms, Facet Joint Diagnostic Blocks (Injections), Facet Joint Radiofrequency Neurotomy

Decision rationale: Regarding the request for lumbosacral medial branch radiofrequency ablation, Occupational Medicine Practice Guidelines state that there is limited evidence that radiofrequency neurotomy may be effective in relieving or reducing lumbar facet joint pain among patients who had a positive response to facet injections. ODG recommends diagnostic injections prior to consideration of facet neurotomy. The criteria for the use of radiofrequency ablation treatment requires a diagnosis of facet joint pain using a medial branch block as described in the guidelines, no more than two levels bilaterally, and there should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. Within the medical records available for review, there was documentation that the injured worker had bilateral L4,5 medial branch blocks on 11/3/2014 with reported 60-70% relief for 4-5 hours after the injections and physical therapy was requested alongside the radiofrequency ablation. Based on the documentation, the injured worker has met the criteria set forth by the guidelines and the currently requested lumbosacral medial branch radiofrequency ablation is medically necessary.

Adjustable Bed, Queen Size with Separate Controls: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Pain Chapter, Mattress selection and on Other Medical Treatment Guideline or Medical Evidence: Medicare Guidelines, Hospital Bed. <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx>

Decision rationale: Regarding the request for a queen sized adjustable bed, with separate controls, the California Medical Treatment and Utilization Schedule and ODG do not contain criteria for the purchase of a hospital bed. ODG guidelines state that there are no high-quality studies to support purchase of any type of specialized mattress or bedding for the treatment for low back pain. Therefore, Medicare guidelines are used. According to Medicare guidelines, the medical necessity of a hospital bed is dependent upon a medical condition in which there is a need for repositioning. This includes patients with severe lower extremity arthritis, severe neurologic injuries such as spinal cord injury or stroke who require frequent repositioning to prevent ulcers, or those with severe cardiac conditions such as congestive heart failure which require body elevation. Within the documentation, the treating physician indicated that a hospital bed was requested to relieve low back pain. However, there was no documentation that

the conditions listed above have been met and no documentation that the injured worker has severe cardiac or neurologic injury that would require automated adjustments such as body repositioning or elevation. Based on the guidelines, the currently requested hospital bed with separate controls is not medically necessary.

Physical Therapy Evaluation plus 12 Sessions for Low Back Pain: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, the treating physician recommended physical therapy evaluation and treatment times 12 for low back pain and worsening radicular symptoms into the left leg. The following specific treatment goals were noted: pain relief and increased mobility. However, the request exceeds the amount of PT recommended by the guidelines and, unfortunately, there is no provision for modification of the current request. For the diagnosis of lumbago, the guidelines recommend 9 visits over 8 weeks. In light of the guidelines recommendations, the currently requested for physical therapy evaluation plus 12 sessions for low back pain is not medically necessary.