

Case Number:	CM15-0144010		
Date Assigned:	08/04/2015	Date of Injury:	12/04/1992
Decision Date:	09/11/2015	UR Denial Date:	06/25/2015
Priority:	Standard	Application Received:	07/24/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 female who sustained a work related injury December 4, 1992. According to a physician's assistants progress notes, dated May 27, 2015, the injured worker presented with low back and bilateral knee pain. She reports, another physician tapped her knees and administered a cortisone injection, which helped. She is having difficulty walking and uses a cane for stabilization. She is currently taking Kadian for chronic pain, Percocet for breakthrough pain, Lyrica for neuropathic pain, Cymbalta, Flexeril, Restoril, Lidoderm patches and Flector patches. She describes her low back pain as stabbing with burning in her left lower extremity and tingling in her left foot. She rates her pain 8 out of 10 without medication and 3 out of 10 with medication. Objective findings included; 5'4" and 200 pounds; antalgic gait with cane; Patrick's sign and Gaensien's maneuver are negative and straight leg raise is negative bilaterally. There is mild joint effusion in both knees, crepitus audible with passive and active flexion and extension, and pain with valgus-varus stress and McMurray's bilaterally but no instability appreciated. Knee flexion is 0-135 degrees on the right and 0-125 degrees on the left. Although the injured worker received treatment from an orthopedist, she does not have a comfort level to return for care and would like another physician. Diagnoses are chronic low back pain; complex regional pain syndrome, left lower extremity; chronic pain syndrome; chronic bilateral knee pain- status post 5 surgeries; lumbar radiculopathy; depression; spinal cord stimulator implant. At issue, is the request for authorization for Percocet, coccyx injection, and second opinion orthopedic consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Percocet 10mg: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Criteria for use of Opioids Page(s): 60,61, 76-78, 88,89.

Decision rationale: Based on the 07/30/15 progress report provided by treating physician, the patient presents with low back/coccyx and bilateral knee pain. The patient is status post 5 knee surgeries, dates unspecified. The request is for 60 Percocet 10mg. RFA with the request not provided. Patient's diagnosis on 07/30/15 includes chronic low back pain, complex regional pain syndrome of the left lower extremity, degenerative joint disease, lumbar radiculopathy, and chronic pain syndrome. The patient has an antalgic gait and ambulates with a cane. Physical examination to the lumbar spine on 07/30/15 revealed tenderness to palpation to the sciatic notches and sacroiliac joints, and decreased range of motion. Examination of the knees revealed mild joint effusion and pain with valgus-varus stress bilaterally. Audible crepitus and decreased range of motion noted. Treatment to date has included surgeries, spinal cord implant, knee fluid aspiration, and medications. Patient's medications include Flexeril, Cymbalta, Percocet, Oxycodone, and Kadian. The patient is "100% disabled," per 06/25/15 report. Treatment reports provided from 01/07/15 - 07/30/15. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS p77 states, "Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Percocet has been included in patient's medications, per progress reports dated 01/07/15, 04/29/15, and 06/25/15. Per 07/30/15 report, treater states the patient reports "pain levels are 8-9/10 without medications and 2/10 with medication pain medications are helping and that she is able to get around and do light chores around the house. She is able to walk for 5-10 minutes at a time, with a cane, with the help of her medications. She is able to go out be more social, which improves her quality of life and mental health. She continues to find her medications helpful. She tolerates them well and takes them as prescribed. Percocet for breakthrough pain deny any significant side effects with the medications. There is no aberrant behavior. The patient has signed an opioid contract CURES was checked and is consistent. The patient was seen in our office on 06/25/15 for an office visit at which time a urine toxicology screening was done consistent with what is being prescribed." In this case, the 4A's have been addressed, adequate documentation has been provided including numeric scales and functional measures that show significant improvement. The request appears to be in accordance with guidelines. Therefore, this request is medically necessary.

One second opinion ortho consult: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-4.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, page 127.

Decision rationale: Based on the 07/30/15 progress report provided by treating physician, the patient presents with low back/coccyx and bilateral knee pain. The patient is status post 5 knee surgeries, dates unspecified. The request is for one-second opinion ortho consult. RFA with the request not provided. Patient's diagnosis on 07/30/15 includes chronic low back pain, complex regional pain syndrome of the left lower extremity, degenerative joint disease, lumbar radiculopathy, and chronic pain syndrome. The patient has an antalgic gait and ambulates with a cane. Physical examination to the lumbar spine on 07/30/15 revealed tenderness to palpation to the sciatic notches and sacroiliac joints, and decreased range of motion. Examination of the knees revealed mild joint effusion and pain with valgus-varus stress bilaterally. Audible crepitus and decreased range of motion noted. Treatment to date has included surgeries, spinal cord implant, knee fluid aspiration, and medications. Patient's medications include Flexeril, Cymbalta, Percocet, Oxycodone, and Kadian. The patient is "100% disabled," per 06/25/15 report. Treatment reports provided from 01/07/15 - 07/30/15. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, page 127 has the following: "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." Per 07/30/15 report, treater states, "This is a patient that requires treatment for her knee pain by a qualified specialist. She needs fluid drained and injections done. We cannot do that for her in this office as it is not our specialty." ACOEM practice guidelines indicate that it may be appropriate for a physician to seek outside consultation when the course of care could benefit from a specialist. It would appear that the current treater feels uncomfortable with the patient's medical issues and has requested second opinion consultation. Given the patient's continued pain symptoms and diagnosis, this request appears reasonable and may benefit the patient. Therefore, the request is medically necessary.

One Coccyx injection with conscious sedation and fluoroscopic guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter under Injections with Anesthetics and/or steroids, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter under Fluoroscopy (for ESI's).

Decision rationale: Based on the 07/30/15 progress report provided by treating physician, the patient presents with low back/coccyx and bilateral knee pain. The patient is status post 5 knee surgeries, dates unspecified. The request is for one coccyx injection with conscious sedation and

fluoroscopic guidance. RFA with the request not provided. Patient's diagnosis on 07/30/15 includes chronic low back pain, complex regional pain syndrome of the left lower extremity, degenerative joint disease, lumbar radiculopathy, and chronic pain syndrome. The patient has an antalgic gait and ambulates with a cane. Physical examination to the lumbar spine on 07/30/15 revealed tenderness to palpation to the sciatic notches and sacroiliac joints, and decreased range of motion. Examination of the knees revealed mild joint effusion and pain with valgus-varus stress bilaterally. Audible crepitus and decreased range of motion noted. Treatment to date has included surgeries, spinal cord implant, knee fluid aspiration, and medications. Patient's medications include Flexeril, Cymbalta, Percocet, Oxycodone, and Kadian. The patient is "100% disabled," per 06/25/15 report. Treatment reports provided from 01/07/15 - 07/30/15. ODG Guidelines, Pain Chapter under Injections with Anesthetics and/or steroids states, "Consistent with the intent of relieving pain, improving function, decreasing medications, and encouraging return to work, repeat pain and other injections not otherwise specified in a particular section in ODG, should at a very minimum relieve pain to the extent of 50% for a sustained period, and clearly result in documented reduction in pain medications, improved function, and/or return to work." ODG guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Fluoroscopy (for ESI's)', has this to say about fluoroscopy "Recommended. Fluoroscopy is considered important in guiding the needle into the epidural space, as controlled studies have found that medication is misplaced in 13% to 34% of epidural steroid injections that are done without fluoroscopy." Per 07/30/15 report, treater states the patient "finds her coccyx pain very limiting. We feel she would benefit from coccyx injections. We requested authorization to perform coccyx injection with fluoroscopic guidance and conscious sedation. The patient needs pain relief. She should be allowed to try an injection." In this case, the provider is requesting what appears to be a local anesthetic injection. This patient presents with persistent unresolved coccyx pain, physical examination reveals localized tenderness to palpation of the coccyx. These symptoms have not responded to conservative therapies such as NSAID medications, physical therapy, and chiropractic treatment. There is also no indication in the records provided that this patient has had injections of any kind directed at this complaint. Given this patient's subjective complaints and physical examination findings, an injection of a local anesthetic agent would appear reasonable. However, the request as stated indicates fluoroscopic guidance. Coccyx injection does not require fluoroscope or anesthesia other than a local block. It is a fairly superficial injection, performed around the painful area. Use of Fluoroscope would not be indicated and not be in accordance with guidelines. Therefore, the request is not medically necessary.