

Case Number:	CM15-0167192		
Date Assigned:	09/04/2015	Date of Injury:	10/21/2002
Decision Date:	10/13/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/25/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 55-year-old female who sustained an industrial injury on 10-21-02. Initial complaints include low back and left shoulder injuries. Initial diagnoses are not available. Treatments to date include medications and injections. Diagnostic studies include MRIs. Current complaints include lumbar spine pain. Current diagnoses include long-term use of medications, degeneration of the lumbar or lumbosacral discs, and neck pain. In a progress note dated 07-24-15, the treating provider reports the plan of care as medications including methadone, Ambien, and topiramate-topamax, as well as bilateral L3-L5 facet injections. The requested treatments include methadone and L3-L5 bilateral facet injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Methadone.

Decision rationale: MTUS does not discourage use of opioids past 2 weeks, but does state that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include the following: 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. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The treating physician does not fully document the least reported pain over the period since last assessment or duration of pain relief. The treating physician does report the worker has returned to work. The UR modified the request to allow for weaning which is appropriate. As such, the request for methadone 10 mg, #90 is not medically necessary.

1 L3, L4, and L5 bilateral facet injection: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, and Facet joint injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back & Lumbar & Thoracic (Acute & Chronic), Facet joint diagnostic blocks (injections) and Other Medical Treatment Guidelines MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections.

Decision rationale: ACOEM Guidelines state, "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain." MTUS is silent specifically with regards to facet injections, but does refer to epidural steroid injections. ODG and MD Guidelines agree that: "One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended . . . If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported." ODG details additional guidelines: 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 and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of

no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level.] Treatment notes did not detail what conservative treatment resulted in failures. The worker has received a previous set of facet joint injections with 50% improvement but duration is not specified. At this time, it is unclear whether the improvement lasted for the 6-8 weeks as recommended. As such, the request for Bilateral Lumbar L4-5 and L5-S1 Facet Joint Injection with Steroid is not medically necessary.