

Case Number:	CM14-0103501		
Date Assigned:	07/30/2014	Date of Injury:	07/02/2005
Decision Date:	09/19/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/03/2014

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 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 79-year-old male who reported an injury on 07/02/2005. The mechanism of injury was a fall. The diagnoses included chronic low back pain, thoracic spine pain, spondylolisthesis, lumbar degenerative disc disease, lumbar facet syndrome, and lumbar spinal stenosis. Previous treatments included medication, physical therapy, epidural steroid injections, and radiofrequency ablation in 09/2012. Within the clinical note dated 06/11/2014, it was reported the injured worker complained of significant low back pain. He reported the pain became severe, that it causes him to walk in a forward flex posture. Upon the physical examination, the provider noted the range of motion of the lumbar spine was significantly limited secondary to pain. There was tenderness to palpation over the paraspinal muscles in the lumbar region bilaterally. The provider noted the injured worker had significant relief from pain from his previous radiofrequency ablation in 2012. The provider requested a repeat radiofrequency ablation at L3, L4, and L5 bilaterally, Oxycontin and Percocet. The Request for Authorization was provided and submitted on the 06/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 40 mg, QTY: 60, plus post dated prescription: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The request for Oxycontin 40 mg, QTY: 60, plus post dated prescription is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the medication had been providing objective functional improvement and benefit. The provider failed to document an adequate and complete pain assessment within the documentation. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.

Percocet 10/325 mg, QTY: 120, plus post dated prescription: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The request for Percocet 10/325 mg, QTY: 120, plus post dated prescription is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the medication had been providing objective functional improvement and benefit. The provider failed to document an adequate and complete pain assessment within the documentation. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Bilateral radiofrequency ablation injections at L3, L4 and L5: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet joint radiofrequency neurotomy.

Decision rationale: The request for Bilateral radiofrequency ablation injections at L3, L4 and L5 is not medically necessary. The California MTUS/ACOEM 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 spine. Lumbar facet neurotomies reportedly produce

mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch blocks. In addition, the Official Disability Guidelines further state facet joint radiofrequency neurotomy is recommended as a treatment that requires a diagnosis of facet joint pain using a medial branch block. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at greater than 50% that is sustained for at least 6 months. Approval of repeat neurotomies depends on the variables, such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medication, and documented improvement in function. The guidelines note no more than 2 joint levels are to be performed at 1 time. The request submitted for bilateral radiofrequency ablation at L3, L4 and L5 exceeds the guidelines' recommendations of no more than 2 joint levels to be injected at 1 time. The requesting physician did not include adequate documentation of significant physical exam findings concurrent with facetogenic pain. There is a lack of documentation indicating measurable functional deficits and improvements. Therefore, the request is not medically necessary.