

Case Number:	CM14-0148889		
Date Assigned:	09/18/2014	Date of Injury:	06/16/2006
Decision Date:	10/29/2014	UR Denial Date:	09/03/2014
Priority:	Standard	Application Received:	09/12/2014

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 Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 49 year old female with a work injury dated 6/16/06. The diagnoses include lumbar intervertebral disc without myelopathy, disc protrusion L4-L5 with bilateral neuroforaminal narrowing rule out new pathology, and thoracic or lumbosacral neuritis or radiculitis unspecified. Under consideration is a request for urine drug screen and radiofrequency bilateral lumbar facet medial branch neurotomy under flouroscopy at L4-L5, L5-S1 level. There is a primary treating physician report dated 6/25/14 that states that the patient had greater than 70% relief after a lumbar transforaminal epidural injection but the low back pain persists and is stabbing. The pain is interfering with ADLs. Her meds include Norco, MSIR, Celebrex and Soma. There is no addiction or diversion evidence. On exam there is paraspinal and facet tenderness. The patient is neurologically intact. The plan includes diagnostic medial branch block and refill of meds and urine drug screen. On 7/8/14 the patient underwent a left lumbar facet injection under fluoroscopy at L3-L4, L4-L5, and L5-S1 (medial branch block) and a right lumbar facet injection under fluoroscopy at L3-L4, L4-L5, and L5-S 1 (medial branch block). An 8/8/14 document states that the patient complains of constant pain in her lower back at 9/10. The pain radiates from her back to her hips and down her legs through her knees and ankles, worse on the left side. Per documentation the patient was recently authorized for a lumbar laminectomy and discectomy at L5-S1 according to a utilization review letter of certification on 08/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, screening for risk of addiction(tests), Opioids, steps to. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Urine Drug Testing (UDT), Criteria for Use of Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines DRUG TESTING; OPIOIDS, STEPS TO AVOID MISUSE/ADDICTION Page(s): 43; 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain(chronic): Urine drug testing (UDT)

Decision rationale: Urine drug screen is not medically necessary per the MTUS and ODG guidelines. The MTUS guidelines state that frequent random urine toxicology screens can be used as a step steps to avoid misuse of opioids, and in particular, for those at high risk of abuse. The MTUS states that urine drug screen is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. The claimant has had a urine drug screen on 04/24/14 and again on 07/10/14. The documentatation does not reveal evidence of aberrant behavior. The ODG states patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders. The documentation is not clear on why with no evidence of aberrant behavior and 2 recent urine drug screens, why an additional urine drug screen is medically necessary. The request for urine drug screen is not medically necessary.

Radiofrequency bilateral lumbar facet medial branch neurotomy under flouroscopy at L4-L5, L5-S1 level: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Facet Joint Diagnostic Block (Injections)

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) Lumbar Facet joint diagnostic blocks (injections)

Decision rationale: Radiofrequency bilateral lumbar facet medial branch neurotomy under flouroscopy at L4-L5, L5-S1 level is not medically necessary per the MTUS and ODG Guidelines. The MTUS state that 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. The ODG states that diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. The

documentation indicates that the patient was authorized for a lumbar laminectomy and discectomy at L5-S1. It is not clear why a radiofrequency neurotomy would be required in this case. Additionally the documentation suggests the the patient's symptoms are not purely facet related and that there is a radicular component. The request for radiofrequency bilateral lumbar facet medial branch neurotomy under flouroscopy at L4-L5, L5-S1 level is not medically necessary.