

<b>Case Number:</b>	CM14-0160990		
<b>Date Assigned:</b>	10/06/2014	<b>Date of Injury:</b>	06/16/2006
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	09/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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 49 year-old female with a date of injury of June 16, 2006. The patient's industrially related diagnoses include lumbar spondylosis without myelopathy, bilateral lumbar facet syndrome, and mechanical low back pain. The injured worker is status post diagnostic lumbar facet injection (medial branch block) on 7/8/2014 with positive results (80% relief). The injured worker tried and failed conservative therapies for pain control (physical therapy modalities, activity modification, chiropractic treatment, anti-inflammatory medications, and muscle relaxants) for more than 3 months. An MRI of the lumbar spine done on 5/27/2014 revealed disc and facet abnormalities. The disputed issues are a request for urine drug screen and for radiofrequency to bilateral lumbar facet (medial branch neurotomy) at L4-L5, L5-S1 level under fluroscopy, one side at a time, two weeks apart. A utilization review determination on 9/19/2014 had non-certified these requests. The stated rationale for the denial of radiofrequency to bilateral lumbar facet was: "There is no documented rationale as to why a lumbar facet rhizotomy is being requested at the same time and same level as the proposed surgery." The injured worker was recently authorized for a lumbar laminectomy and discectomy at L5-S1 on 8/25/2014 and the ODG states that diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. The stated rationale for the denial of the urine drug screen was: "The patient had undergone multiple recent urine drug screens, most recently on 4/24/14 and again on 7/10/14; however, there are no records of the results in the reports provided, nor is there documentation of aberrant behavior or medication misuse or abuse." The treating provider submitted a letter of appeal referencing the UR denial; however, there was no additional information in the letter specific to the urine drug screen that supported the urine drug screen request.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Radio frequency bilateral lumbar facet (medial branch neurotomy) at L4-L5, L5-S1 level under fluroscopy, one side at a time, two weeks apart:** 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:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Facet Joint Pain, Signs & Symptoms, Facet Joint Diagnostic Blocks (Injections), Facet Joint Radiofrequency Neurotomy

**Decision rationale:** Lumbar radiofrequency ablation is not specifically addressed within the Chronic Pain Medical Treatment Guidelines. ACOEM Medical Practice Guidelines, 2nd edition, 2004, Chapter 12 states on page 300: "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. 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." More specific guidelines with regard to radiofrequency ablation can be found in the Official Disability Guidelines (ODG) which state that conflicting evidence is available as to the efficacy of lumbar facet joint radiofrequency neurotomy and approval of treatment should be made on a case-by-case basis." The criteria for use of facet joint radiofrequency neurotomy provided in the ODG include the following: Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. No more than two joint levels are to be performed at one time. If different regions require neural blockades, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. For facet joint diagnostic blocks, the ODG states: "Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated." In the progress reports available for review, the injured worker had diagnostic lumbar facet injections on 7/8/2014 with positive results of greater than 75% relief reported. Furthermore, there are subjective and objective findings consistent with facet joint pain documented on the progress report dated 8/11/2014 when the request for radiofrequency was made. However, in a progress report dated 8/1/2014, the treating physician documented that the consulting surgeon recommended lumbar laminectomy and discectomy at L5-S1. The treating physician agreed with the decision regarding surgery at L5-S1 and the injured worker indicated that she too wanted to have surgery. In the utilization review, it is documented that the injured worker was authorized for the lumbar laminectomy and discectomy at L5-S1 on 8/25/2014. Based on the guidelines, a diagnostic facet block should not be performed in patients in whom a surgical procedure is anticipated. However, the diagnostic facet block was performed a month before the surgery was authorized. Therefore, there is no clear indication for proceeding with the radiofrequency neurotomy since the injured worker is now anticipating surgery. Based on the guidelines, the request for radiofrequency bilateral

lumbar facet (medial branch neurotomy) at L4-L5, L5-S1 level under fluoroscopy, one side at a time, two weeks apart, is not medically necessary.

**Urine drug screen:** Overturned

**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:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Testing, Opioids, Page(s): 43,76-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommend urine drug testing (UDT) as an option to assess for the use or the presence of illegal drugs and for evaluation of possible aberrant drug-related behavior. While on opioids, on-going management actions should include: "Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects." Urine drug screens can help determine appropriate medication use and identify possible aberrant behavior. In regard to the frequency of urine drug testing, the Official Disability Guidelines state that there is no hard and fast rule in terms of frequency of drug testing, but risk stratification appears to be the best way to determine frequency. It is currently recommended that patients at low risk of adverse outcomes be monitored randomly at approximately every six months. A 3- to 4-time a year frequency is recommended for patients at intermediate risk, those undergoing prescribed opioid changes without success, patients with a stable addiction disorder, those patients in unstable and/or dysfunctional social situations, and for those patients with comorbid psychiatric pathology. Those patients at high risk of adverse outcomes may require testing as often as once a month." In the progress reports available for review, there was no clinical evidence that the injured worker presented with any aberrant behavior, however, the injured worker is prescribed two narcotics for the management of her pain: Norco and Morphine Sulfate Extended Release. A urine drug screen (UDS) was requested repeatedly, but there was no evidence that a UDS was completed. Based on the guidelines referenced above, a patient at low risk of adverse outcomes should be monitored approximately every six months. In the Utilization Review report, the stated rationale for the non-certification of the request was: "The patient had undergone multiple recent urine drug screens, most recently on 4/24/14 and again on 7/10/14." However, there was no documentation in the available reports that a UDT was performed on those dates and there were no documented results. The submitted documentation indicated that point of care six-panel urine toxicology testing was done on 8/18/2014, which was consistent with the injured worker's prescribed medications. However, this was a baseline report and the treating physician requested urine toxicology quantitative and confirmatory screening. Based on the guidelines and the documentation, the request for a urine drug screen is medically necessary.