

Case Number:	CM14-0184225		
Date Assigned:	11/13/2014	Date of Injury:	11/23/1997
Decision Date:	12/19/2014	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/04/2014

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 Internal Medicine, and is licensed to practice in New York. 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 claimant is a 49 year old female who sustained an industrial injury on 11/23/1997. Her diagnoses include back pain, bilateral knee pain, and headaches. She is s/p two arthroscopic knee surgeries and s/p right total knee arthroplasty in 11/2013. On physical exam she has decreased range of cervical motion in extension and left lateral rotation, bilateral facet pain with left lateral rotation facet loading, normal gait, and positive right straight leg raising. There is bilateral knee swelling with negative McMurray's test bilaterally. Treatment in addition to surgery has included medical therapy with narcotics, physical therapy and epidural steroid injections. The treating provider has requested (1) Right Knee Nerve Block, (1) set of Transforaminal epidural steroid injections on the right at L3, L4 and L5 under fluoroscopic guidance, (1) Prescription of Percocet 10/325mg #90, (1) Prescription of Parafon Forte DSC 500mg #90, and 1 Urine Drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

(1) Right Knee Nerve Block: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve blocks

Decision rationale: There is no documentation provided necessitating the requested right knee nerve block. Per the documentation the claimant underwent a right total knee arthroplasty 11/2013 after which she was non-compliant with recommendations for post-surgical physical therapy and medical follow-up. Due to the lack of support of the evidence based guidelines for the use of nerve blocks in the treatment of knee pain, and lack of documentation of failure of more conservative treatment such as physical medicine, the request for radiofrequency neurotomy is not appropriate. Medical necessity for the requested treatment has not been established. The requested item is not medically necessary.

(1) set of Transforaminal epidural steroid injections on the right at L3, L4 and L5 under fluoroscopic guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS Guidelines 2009 Page(s): 46.

Decision rationale: Per the reviewed guidelines epidural injections are appropriate in cases of radicular pain when documented by physical examination, and corroborated by imaging studies and/or electrodiagnostic testing if the condition is initially unresponsive to conservative treatments. The Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. Medical necessity for the requested lumbar steroid injection has been established. The requested treatment is medically necessary. In this case there is no documentation of objective findings of a radicular cause of pain such as numbness or tingling in a dermatomal pattern, muscle weakness in a myotomal pattern or deep tendon reflexes abnormalities. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

(1) Prescription of Percocet 10/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Guidelines 2009 Page(s): 91-97.

Decision rationale: The documentation indicates the enrollee has been treated with opioid therapy with Percocet 10/325mg. Per California MTUS Guidelines, short-acting opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the

medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient has continued pain despite the continued use of short acting opioid medications. The patient may require a multidisciplinary evaluation to determine the best approach to treatment of his chronic pain syndrome. The requested treatment is not medically necessary.

(1) Prescription of Parafon Forte DSC 500mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Parafon Forte (chiorzoxazone).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS 2009 Page(s): 64.

Decision rationale: Per California MTUS Guidelines muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for this muscle relaxants medication has not been established. The requested treatment is not medically necessary.

1 Urine Drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines, Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: Per Chronic Pain Management Treatment Guidelines, urine screening is recommended in chronic pain patients to differentiate dependence and addiction with opioids as well as compliance and potential misuse of other medications. The documentation indicates the claimant underwent urine screening in 7/2014 and there is no rationale to support the use of drug screening more than the recommended once per year. Due to the fact that the most recent urine test was three months prior, medical necessity for the requested test has not been established. The requested test is not medically necessary.