

Case Number:	CM15-0126140		
Date Assigned:	07/10/2015	Date of Injury:	08/02/2005
Decision Date:	09/24/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/30/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 52-year-old female who sustained an industrial injury on 8/2/05. The injured worker was diagnosed as having lumbago, sacroiliac joint pain and post-traumatic stress disorder. Currently, the injured worker was with complaints of difficulties with activities of daily living due to limited range of motion. Previous treatments included injection therapy, oral pain medication, and transcutaneous electrical nerve stimulation unit, use of a walker, psychiatric therapy, and transportation assistance. Previous diagnostic studies included radiographic studies, bone scan and magnetic resonance imaging. The injured work status was noted as Temporary Total Disability. The injured workers pain level was noted as a 6/10. Physical examination was not noted. The plan of care was for Oxymorphone 40 milligrams quantity of 120, Home healthcare 4 hours a day 3 days a week and radiofrequency neurolysis of the right sacroiliac joint under fluoroscopic guidance with general/MAC.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxymorphone 40mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines When to Discontinue Opioids; When to Continue Opioids; Opioids for Chronic Pain; Weaning of Medications Page(s): 79, 80, 81, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88, 89.

Decision rationale: The patient presents with low back pain and bilateral sacroiliac joint. The request is for OXYMORPHONE 40 MG, #120. Patient is status post low back surgery, date unspecified. Physical examination to the lumbar spine on 04/23/15 revealed tenderness to palpation over the sacroiliac joint bilaterally. Per 06/04/15 progress report, patient's diagnosis include back-lumbar spine, neck, thoracic spine, bilateral lower extremities - lumbar radiculopathy, internal, psyche - pain syndrome associated with medical and psychological condition, depression chronic - major depression - panic attacks, obstructive sleep apnea, and insomnia. Patient's treatments have included medications and injections with benefits. Patient's medications, per 05/03/15 progress report include Oxymorphone, and Robaxin. Patient is temporarily totally disabled. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS p77 states, "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Pages 80, 81 of MTUS also states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." MTUS p90, maximum dose for Hydrocodone, 60mg/day. The treater does not specifically discuss this request. The progress reports from 01/01/15 through 07/07/15 all list Oxymorphone but does not adequately discuss its impact on the patient's pain and function. No before and after pain scales are used for analgesia. No ADL's are discussed showing specific functional improvement. No UDS, CURES reports, and no adverse effect and other measures of aberrant behavior are discussed either. Outcome measures are not discussed and no validated instruments are used showing functional improvement as required by MTUS. Given the lack of documentation, as required by the guidelines, the request IS NOT medically necessary.

Home healthcare 4 hours a day 3 days a week: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: The patient presents with low back pain and bilateral sacroiliac joint. The request is for HOME HEALTHCARE 4 HOURS A DAY 3 DAYS A WEEK. Patient is status post low back surgery, date unspecified. Physical examination to the lumbar spine on 04/23/15 revealed tenderness to palpation over the sacroiliac joint bilaterally. Per 06/04/15 progress report, patient's diagnosis include back-lumbar spine, neck, thoracic spine, bilateral lower extremities - lumbar radiculopathy, internal, psyche - pain syndrome associated with medical

and psychological condition, depression chronic - major depression - panic attacks, obstructive sleep apnea, and insomnia. Patient's treatments have included medications and injections with benefits. Patient's medications, per 05/03/15 progress report include Oxymorphone, and Robaxin. Patient is temporarily totally disabled. MTUS Guidelines page 51, Home Health Services Section states: "Recommended only for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed." In progress report dated 06/04/15 through 07/17/15, treater states that the patient reports experiencing increased difficulties with activities of daily living due to her limited range of motion and patient is in need of home health services as related to her bathing and foot care. In this case, the treater has not documented any foot issues that would require home health care. Furthermore, MTUS does not support home health service for bathing. Therefore, the request IS NOT medically necessary.

Radiofrequency neurolysis of the right sacroiliac joint under fluoroscopic guidance with general/MAC: 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), SI joint Neurotomies.

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 - Lumbar & Thoracic (Acute & Chronic) chapter, under Facet joint radiofrequency neurotomy.

Decision rationale: The patient presents with low back pain and bilateral sacroiliac joint. The request is for RADIOFREQUENCY NEUROLYSIS OF THE RIGHT SACROILIAC JOINT UNDER FLUOROSCOPIC GUIDANCE WITH GENERAL/MAC. Patient is status post low back surgery, date unspecified. Physical examination to the lumbar spine on 04/23/15 revealed tenderness to palpation over the sacroiliac joint bilaterally. Per 06/04/15 progress report, patient's diagnosis include back-lumbar spine, neck, thoracic spine, bilateral lower extremities - lumbar radiculopathy, internal, psyche - pain syndrome associated with medical and psychological condition, depression chronic - major depression - panic attacks, obstructive sleep apnea, and insomnia. Patient's treatments have included medications and injections with benefits. Patient's medications, per 05/03/15 progress report include Oxymorphone, and Robaxin. Patient is temporarily totally disabled. ODG, Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, under Facet joint radiofrequency neurotomy states: "Criteria for use of facet joint radiofrequency neurotomy: 1. Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections). 2. While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief, generally of at least 6 months duration. No more than 3 procedures should be performed in a year's period. 3. Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. 4. No more than two joint levels are to be performed at one time. 5. If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. 6. There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy." In

progress report dated 03/01/15 through 03/31/15, treater states that the patient's lumbar MRI helped clarify the SI joint as the likely source of the pain for the low back and hip area. The treater further states that this was addressed with an SI joint injection completed under MAC sedation with excellent results, about 90% relief. ODG guidelines support RF neurotomy when the source of pain is confirmed to be facet joint. However, treater has not documented the reason for requesting general MAC sedation. ODG guidelines do not support general MAC sedation for this procedure. Therefore, the request IS NOT medically necessary.