

Case Number:	CM15-0061152		
Date Assigned:	04/07/2015	Date of Injury:	02/09/2006
Decision Date:	05/29/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	03/31/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 61 year old male with a reported injury on February 9, 2009. The mechanism of injury was a motor vehicle accident. He reported low back pain, sleep disturbances, anxiety and post-traumatic stress disorder. The injured worker was diagnosed as having lumbosacral radiculopathy, neuropathic pain syndrome, degenerative lumbar disc disease, facet syndrome, sacral radiculopathy, anxiety disorder and obsessive-compulsive disorder. Treatment to date has included radiographic imaging, diagnostic studies, radiofrequency ablations, epidural injections, pain injections, medial branch blocks, psychotherapy, medications, conservative therapies and retirement. Recently, the injured worker complained of chronic low back pain, anxiety, nervousness and sleep disturbances. He has been treated conservatively and surgically without complete resolution of the pain. It was noted he became nervous in the evenings and experienced weight loss since the accident. Evaluation on October 7, 2014, revealed continued pain. He noted requiring pain medications and sleep aides to remain functional. Medications, radiofrequency ablation in the lumbar and sacral spine areas, medications and a B-12 injection were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency Ablation At Right L5-S1 (QTY: 1): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Facet joint radiofrequency neurotomy.

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

Decision rationale: The request for radiofrequency ablation at right L5-S1 (QTY: 1) is not medically necessary. The California MTUS/ACOEM Guidelines state that facet neurotomy should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The documentation provided for review did not include documentation of a right L5-S1 medial branch block, or the results of such a block. As such, the requested service is not supported. Therefore, the radiofrequency ablation at right L5-S1 (QTY: 1) is not medically necessary.

Radiofrequency Ablation At Right L4-L5 (QtY: 1): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Facet joint radiofrequency neurotomy.

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

Decision rationale: The request for radiofrequency ablation at right L4-L5 (QtY: 1) is not medically necessary. The California MTUS/ACOEM Guidelines state that there is good quality medical literature demonstrating that radiofrequency neurotomy and facet joint nerves in the cervical spine provides good temporary relief of pain, but similar quality literature does not exist regarding the same procedure in the lumbar region. The California MTUS/ACOEM Guidelines do not address repeat radiofrequency ablation. The Official Disability Guidelines state that repeat neurotomy should not occur at an interval of less than 6 months from the first procedure, and a neurotomy should not be repeated unless the duration of relief from the first procedure is documented for at least 12 weeks at greater than or equal to 50% relief. The provided documentation indicated that the injured worker had a right L4 and L5 radiofrequency ablation on 10/14/2014. Documentation from 11/06/2014 indicates that the injured worker had 30% pain relief, but that the relief was waning. As such, a repeat radiofrequency ablation is not supported. Therefore, the request for radiofrequency ablation at right L4-L5 (QtY: 1) is not medically necessary.

Retrospective Toradol Injection, DOS: 03/19/2015 (QtY: 1): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 73.

Decision rationale: The request for retrospective toradol injection, DOS: 03/19/2015 (QtY: 1) is not medically necessary. The California MTUS Chronic Pain Guidelines state that toradol/ketorolac is not indicated for minor or chronic painful conditions. The provided documentation indicates that the intramuscular injection of toradol was performed due to the injured worker's chronic pain syndrome. As such, the requested retrospective service is not supported. Therefore, the request for retrospective toradol injection, DOS: 03/19/2015 (QtY: 1) is not medically necessary.

Retrospective B12 Injection, DOS: 03/19/2015 (QtY: 1): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Vitamins B12.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Vitamin B.

Decision rationale: The request for retrospective B12 Injection, DOS: 03/19/2015 (QtY: 1) is not medically necessary. The California MTUS/ACOEM Guidelines do not address vitamin B12 injections, so the Official Disability Guidelines were consulted. The Official Disability Guidelines do not recommend vitamin B for the treatment of chronic pain. As such, the requested service is not supported. Therefore, the request for retrospective B12 Injection, DOS: 03/19/2015 (QtY: 1) is not medically necessary.

Percocet 10/325 Qty 720: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 79-80.

Decision rationale: The request for Percocet 10/325 Qty 720 is not medically necessary. A previous utilization review dated 03/30/2015 approved a modified number of Percocet 10/325 mg for #180 tablets. The California MTUS Chronic Pain Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects for patients taking opioid medication. The guidelines also indicate that after 4 months of therapy with opioid medications, the frequency of visits should be every 6 to 8 weeks. The most recent clinical note provided for review did not include documentation of efficacy regarding opioid use and reported stable rather than improving functionality. Additionally, while the office visit note dated 03/19/2015 indicated no aberrant drug related behaviors, urine drug screen on 12/04/2014 was not consistent with the injured worker's prescribed medications. As such, continued use of opioid medications is not supported, and the prior utilization review determination of a

modification was appropriate. Furthermore, the provided documentation indicated that the injured worker was taking Percocet 10/325 mg every 4 hours as needed for pain, and indicated a prescription for 180 tablets while the request is for 720 tablets. As such, the requested service is not supported. Therefore, the request for Percocet 10/325 Qty 720 is not medically necessary.