

Case Number:	CM14-0152380		
Date Assigned:	09/22/2014	Date of Injury:	03/02/2006
Decision Date:	11/04/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/18/2014

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 and is licensed to practice in Texas and Ohio. 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 66-year-old female who reported an injury on 03/02/2006 while rearranging food cans in the pantry and was on a step ladder, she stood on her toes to move some overhead cans about 1 foot when she felt a muscle pull in her lower back. The diagnoses were impingement right shoulder, failed back surgery syndrome, and bilateral sacroiliac joint pain. The past treatments were medications, physical therapy and injections into the right hip bursa. Physical examination on 07/31/2014 revealed complaints of low back, buttocks and hand pain that continued to remain the same. The injured worker recently had a shoulder injection. It was reported that without medications and injection therapy the injured worker would be very limited. Examination revealed that the injured worker used a cane to ambulate. There was axial tenderness upon palpation of the lumbar spine. Range of motion revealed pain with extension and rotation. Palpation of the pelvis revealed significant tenderness to palpation over bilateral (right side was more tender than left side) sacroiliac joint, piriformis and trochanter. Faber was positive bilaterally. There was pain with flexion and internal rotation bilateral hips. Medications were OxyContin, Percocet, and Valium. Treatment plan was for medications as directed and bilateral sacroiliac joint injections with fluoroscopy and IV sedation. The rationale was not submitted. The Request for Authorization was submitted for her review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Oxycontin 20mg, QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycontin, Ongoing Management, Page(s): 78, 75.

Decision rationale: The decision for retrospective request for OxyContin 20 mg, quantity 60 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend long acting opioids (OxyContin) for around the clock pain relief and indicate it is not for use as needed. The medical guidelines recommend that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behaviors. The 4A's for ongoing monitoring of an opioid medication was not reported. The request does not indicate a frequency for the medication. The efficacy of this medication was not reported. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

Retrospective request for Percocet 10/325mg, QTY: 240, dispensed on 08/25/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percocet (Oxycodone and Acetaminophen).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percocet, Ongoing Management, Page(s): 75, 78.

Decision rationale: The decision for retrospective request for Percocet 10/325 mg, quantity 240, dispensed on 08/25/2014 is not medically necessary. The California Medical Treatment Utilization Schedule guidelines recommend Oxycodone/Acetaminophen (Percocet) for moderate to severe chronic pain and that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behaviors. There was no documentation of the 4A's for ongoing monitoring of an opioid medication. The efficacy of this medication was not reported. Objectionable functional improvement was not reported. The request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Bilateral sacroiliac joint injections with fluoroscopy and IV (intravenous) sedation:
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), Hip and pelvis (Acute and Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis, Sacroiliac Joint Blocks

Decision rationale: The decision for bilateral sacroiliac joint injections with fluoroscopy and IV (intravenous) sedation is not medically necessary. The Official Disability Guidelines states that for sacroiliac joint blocks there should be specific tests for motion palpation and pain provocation that have been described for SI joint dysfunction such as cranial sheer test, extension test, flamingo test, Patrick's test, Gillet's test, Gaenslen's test, thigh thrust test, pelvic rock test, sacroiliac sheer test, pelvic distraction test. Indications for sacroiliac joint blocks are history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). Diagnostic evaluation must first address any other possible pain generators, the injured worker has had failed at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercise and medication management, blocks are performed under fluoroscopy, a positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least a greater than 70% pain relief recorded for this period. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least greater than 70% pain relief is obtained for 6 weeks. The block is not to be performed on the same day as a lumbar epidural steroid injections (ESI), transforaminal ESI, facet joint injection or medial branch block. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year.