

Case Number:	CM13-0062208		
Date Assigned:	12/30/2013	Date of Injury:	06/24/2006
Decision Date:	08/06/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	12/06/2013

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 Nevada. 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 55-year-old individual, who was reportedly injured on June 24, 2006. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated November 12, 2013, indicates that there are ongoing complaints of low back, and lower extremity pain. The physical examination demonstrated lumbar spine: positive tenderness to palpation spinous, Paris minus, lumbar, gluteal, sacroiliac (SI) joint and posterior superior iliac spin. Motion is with pain. Positive results for the Patrick's, Faber test on the right. There was a positive facet loading test on the left. The lower extremity had normal muscle strength, normal, neurovascular, and normal neurologic findings. No recent diagnostic studies are available for review. The previous treatment includes previous radio frequency facet Rhizotomy, psychiatric consultation, epidural steroid injections and medications to include Ambien, Butrans, Naproxen, Neurontin, Norco 10/325 and Zoloft 100 mg and 50 mg. A request had been made for Zoloft 100mg # 30 with three (3) refills, Norco 10/325mg 3120 with two (2) refills, Zoloft 50mg #30 with four (4) refills and radiofrequency lumbar bilaterally L3-4, L4-5, and L5-S1, which was not certified in the pre-authorization process on November 18, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) prescription of Zoloft 100mg #30, with three (3) refills: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (selective serotonin reuptake inhibitors) Page(s): 107.

Decision rationale: The Chronic Pain Guidelines indicate that selective serotonin reuptake inhibitors are not recommended for the treatment of chronic pain, but may be beneficial for the treatment of psychosocial symptoms associated with chronic pain. Based on the clinical documentation provided, this medication is being utilized to treat reactionary depression/anxiety secondary to the chronic pain. As such, the requested medication is medically necessary.

Norco 10/325mg #120, with two (2) refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-78.

Decision rationale: Norco (Hydrocodone/acetaminophen) is a short-acting opioid combined with acetaminophen. The Chronic Pain Guidelines support short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured worker suffers from chronic low back pain; however, there is no objective clinical documentation of improvement in their pain or function with the current regimen. It is noted the position states an 80% improvement in pain for a few hours after the use of this medication, but no other details discussing improvement in function are noted. As such, this request is not considered medically necessary.

One (1) prescription of Zoloft 50mg #30, with four (4) refills: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (selective serotonin reuptake inhibitors) Page(s): 107.

Decision rationale: The Chronic Pain Guidelines indicate that selective serotonin reuptake inhibitors are not recommended for the treatment of chronic pain, but may be beneficial for the treatment of psychosocial symptoms associated with chronic pain. Based on the clinical documentation provided, this medication is being utilized to treat reactionary depression/anxiety secondary to the chronic pain. As such, the requested medication is medically necessary.

One (1) bilateral lumbar radiofrequency of L3-4, L4-5, and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

Decision rationale: There is no recommendation for or against the use of radiofrequency neurotomy or facet Rhizotomy for the treatment of patients with chronic low back confirmed with diagnostic blocks, but who do not have radiculopathy and who have failed conservative treatment. There is no recommendation for a third or for additional procedures. After reviewing the medical documentation provided it is noted that the injured worker does have chronic low back pain, as well as pain in the lower extremities. There is no recommendation for repeated procedures. It is reasonable to attempt a second lesion after twenty-six (26) weeks in patients who had greater than 50% improvement in pain from first procedure for the first eight (8) weeks, with a late return of pain. It is noted that the patient has had more than two (2) radiofrequency ablations in the past. Therefore, the additional request for this procedure is deemed not medically necessary.