

Case Number:	CM13-0063624		
Date Assigned:	01/24/2014	Date of Injury:	04/30/1990
Decision Date:	05/23/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/09/2013

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 Occupational Health and is licensed to practice in California. 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 patient is an employee of [REDACTED] and has submitted a claim for back pain with an industrial injury date of April 30, 1990. Treatment to date has included medications, including Gabapentin 600 mg tabs 2 TID (since June 2012) and Norco 10-325 mg tabs 1 Q 4-6 H (since June 2012); physical therapy, transforaminal epidural corticosteroid injections, paraspinal trigger point injections, SI joint blocks, TENS therapy, lumbar laminectomies, and lumbar radiofrequency neurotomy. Utilization review from November 19, 2013 denied the request for 1 bilateral L3-4 and L4-5 median branch radiofrequency neurotomy because radicular pain was found in the physical examination. The same review also denied the requests for Gabapentin 600 mg and Norco 10/325 mg but the rationale for determination was not included in the records for review. Medical records from 2011 through 2014 were reviewed, which showed that the patient complained of constant back pain, rated 7-10/10, accompanied by neck, shoulder, buttock, testicular, and leg pain. Central back pain is increased with sudden twisting at the waist. It was reported that these symptoms responded to prior radiofrequency neurotomies and were unrelated to his chronic radiculopathy. On physical examination, there was end range of motion stiffness/tenderness of the cervical spine. Lumbar/sacral exam showed surgical scars were present. There was marked tightness of the lumbar paraspinals and there was poor pelvic rotation. There was increased end range of motion stiffness/tenderness on the right side. Facet loading maneuver was positive and there was hypersensitivity of the skin of the lumbosacral spine bilaterally. Range of motion was limited. There was positive straight leg raise test bilaterally. Toe and heel walking were abnormal. Gait was antalgic and posture was hypolordotic at the lumbar region. There was noted decreased motor strength of both lower extremities. Decreased sensation was noted on the right L3-5 dermatomes. Official result of MRI of the lumbar spine is not included in the documents submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL L3-4 AND L4-5 MEDIAN BRANCH RADIOFREQUENCY NEUROTOMY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation NON MTUS ODG, RADIOFREQUENCY NEUROTOMY

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

Decision rationale: According to pages 300-301 of the ACOEM Low Back Chapter, criteria for RFA include evidence of adequate diagnostic blocks, documented improvement in VAS score, documented improvement in function, evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy, and at least 12 weeks at $\geq 50\%$ relief with prior neurotomy. In this case, although previous neurotomy was reported to be beneficial, objective evidence of improvement in function or VAS score were not documented. In addition, there was no discussion regarding a formal plan of conservative management in addition to RFA. The criteria have not been met, therefore, the request for BILATERAL L3-4 AND L4-5 MEDIAN BRANCH RADIOFREQUENCY NEUROTOMY is not medically necessary.

GABAPENTIN 600MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (MAY 2009), GABAPENTIN.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION ON ANTI-EPILEPSY DRUGS (AEDS) Page(s): 16,17.

Decision rationale: The Expert Reviewer's decision rationale: According to pages 16-17 of the Chronic Pain Medical Treatment Guidelines, Gabapentin has been shown to be effective for the treatment of diabetic neuropathy and postherpetic neuralgia. However, there is a lack of expert consensus on the treatment of neuropathic pain and there are no RCTs specifically assessing Gabapentin for painful radiculopathy. In this case, the presence of diabetic neuropathy and postherpetic neuralgia were not documented. In addition, there was no discussion regarding the indication for the use of gabapentin. Therefore, the request for GABAPENTIN 600MG is not medically necessary.

NORCO 10/325MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (MAY 2009), NORCO.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION ON OPIOID TREATMENT Page(s): 79-81.

Decision rationale: According to pages 79-81 of the Chronic Pain Medical Treatment Guidelines, ongoing opioid treatment is not supported unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, the patient has been on opioids since June 2012 but the records do not clearly reflect continued analgesia, continued functional benefit, a lack of adverse side effects, or aberrant behavior. There is also no discussion regarding non-opiate means of pain control or endpoints of treatment. Although opiates may be appropriate, additional information would be necessary. Therefore, the request for NORCO 10/325 MG is not medically necessary.