

Case Number:	CM14-0009048		
Date Assigned:	02/10/2014	Date of Injury:	03/28/2004
Decision Date:	08/05/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/23/2014

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 Anesthesiology, has a subspecialty in Pain Management 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 a 61-year-old male who has submitted a claim for L3-L4 adjacent segment degeneration, L3-L4 stenosis, intermittent right leg radiculopathy, status post L4-S1 fusion, L2-L4 facet arthropathy, bilateral sacroiliac joint dysfunction, and status post right L3-L5 foraminotomy and laminotomy associated with an industrial injury date of March 28, 2004. Medical records from 2011-2014 were reviewed. The patient complained of low back and left thigh pain, rated 3-4/10 in severity. There was also numbness on the left anterior shin. There was increasing complaint of drainage from the patient's post surgical lumbar fusion wound. Physical examination showed tenderness over the left sacroiliac joint and greater trochanter bilaterally. Lumbar range of motion was limited with pain. Reflexes on the knees and ankles were absent. There was decreased sensation over the left L3 and L4 dermatome distribution and right L5 dermatome distribution. Motor strength was intact. MRI of the lumbar spine, dated August 13, 2012, revealed L4-S1 fusion, and degeneration at L3-L4 above the fusion with facet arthropathy and disc displacement which causes severe lateral recess stenosis. CT of the lumbar spine, dated June 21, 2013 showed solid fusion posteriorly at L4-S1, disc degeneration at T11-L4, bridging osteophytes at T11-T12 and T12-L1, and residual foraminal stenosis at L4 bilaterally and L3 bilaterally. Treatment to date has included medications, physical therapy, home exercise program, activity modification, neck surgery, trigger point injection, right and left shoulder surgery, lumbar epidural steroid injection, and lumbar spine fusion surgeries. Utilization review, dated January 2, 2014, did not grant the request for lumbar rhizotomy because there was no documentation of evidence of adequate diagnostic blocks and no more than two joint levels will be performed at one time. The request for Endocet 10/325mg (quantity not specified) was also not granted because there was no documentation of the amount requested.

Finally, Flexeril 10mg (quantity not specified) was not medically necessary as well because there was no documentation of acute muscle spasms and the amount requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR RHIZOTOMY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG), Low Back, Facet Joint Radiofrequency Neurotomy.

Decision rationale: The California MTUS does not specifically address repeat neurotomies. Per the Strength of Evidence, hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and the Official Disability Guidelines (ODG) was used instead. The Official Disability Guidelines states that 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 more than or equal to 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). In this case, patient had undergone previous lumbar rhizotomies. The most recent was dated June 26, 2013. An office visit dated July 23, 2013 stated that the patient noted marked reduction in low back pain from pain score of 10/10 to 2-3/10. However, the documentation did not specify the duration of pain relief from previous rhizotomy. As stated above, repeat neurotomies are not recommended unless duration of relief is at least 12 weeks. Furthermore, the present request did not specify the spinal level and the laterality. Therefore, the request for lumbar rhizotomy is not medically necessary.

ENDOCET 10/325MG (QUANTITY NOT SPECIFIED): Upheld

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

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

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief (analgesia), side effects (adverse side effects), physical and psychosocial functioning (activities of daily living) and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been taking opioids (Percocet) since March 2004 and was on Endocet since January 2014. The patient claims that analgesia from pain medication was adequate. However, specific measures of analgesia and functional improvements

such as improvements in activities of daily living were not documented. There was also no documentation of adverse effects or aberrant drug-taking behaviors. The MTUS Guidelines require clear and concise documentation for ongoing management. Furthermore, the present request did not specify the quantity to be dispensed. Therefore, the request for Endocet 10/325mg (quantity not specified) is not medically necessary.

FLEXERIL 10MG (QUANTITY NOT SPECIFIED): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants. According to pages 41-42 of the California MTUS Chronic Pain Medical Treatment Guidelines, sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain (LBP). However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. In addition, efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. The effect is greatest in the first 4 days of treatment. In this case, the patient has been on Cyclobenzaprine since March 2004. The recent clinical evaluation does not indicate relief of pain and functional improvement of the patient from Cyclobenzaprine use. In addition, the use of Cyclobenzaprine has exceeded the recommended duration of treatment. Furthermore, the present did not specify the quantity to be dispensed. Therefore, the request for Flexeril 10mg (quantity not specified) is not medically necessary.