

Case Number:	CM14-0016700		
Date Assigned:	04/11/2014	Date of Injury:	03/28/2012
Decision Date:	05/29/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/10/2014

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 Occupational Medicine 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 filed a claim for lumbar facet syndrome associated with an industrial injury date of March 28, 2012. Utilization review from February 3, 2014 denied the requests for radiofrequency ablation due to no significant relief from prior injections, an FRP, and is on narcotics. The patient was said to be a poor candidate for radiofrequency ablation. The other requests for Percocet, Valium, and soma were also denied due to lack of efficacy, long-term use, and no support from the guidelines respectively. Treatment to date has included facet joint injections, physical therapy, and oral pain medications. Only medical records from 2012 were presented and reviewed. The patient has tried multiple modalities for the chronic pain. However, in the low back pain persists. The pain is described to be at two-3/10 at best, 8/10 at worst, and 5/10 on average. Movement and activities aggravate the pain. On examination, there were multiple trigger points noted as well as slightly limited range of motion for the lumbar spine. The bilateral lower lumbar facet joints were tender. Neurological exam was normal.

IMR ISSUES, DECISIONS AND RATIONALES

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

RADIOFREQUENCY ABLATION: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Low Back Chapter Facet Joint Radio Frequency Neurotomy.

Decision rationale: CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Low Back Chapter, Facet joint radiofrequency neurotomy was used instead. ODG states that radiofrequency neurotomy may be used after a diagnostic medial branch block has confirmed pain relief of at least >50% with no more than 2 joint levels to be performed on at one time. In this case, the patient suffers from chronic pain. However, the documentation provided did not contain the most recent progress notes to indicate the patient's current functional status. In addition, the request of does not specify a level for the radiofrequency ablation. Therefore, the request for radiofrequency ablation is not medically necessary.

PERCOCET 10/325MG: Upheld

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

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

Decision rationale: Page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. In this case, the patient suffers from chronic pain and has been taking Percocet since 2012. However, the documentation provided did not contain the most recent progress notes to indicate the patient's current functional status to evaluate the effectiveness of the medication. In addition, the request of does not specify an amount to be dispensed. Therefore, the request for Percocet is not medically necessary.

VALIUM 5MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Page(s): 24.

Decision rationale: As stated on page 24 of the California MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because of unproven long-term efficacy and risk of dependence; use is limited to 4 weeks. In this case, the patient has been taking benzodiazepines since 2012. However, the documentation provided did not have the most recent progress notes to indicate the need for continued benzodiazepine use as long-term use is not recommended. As such, there is no discussion concerning the need for

variance from the guidelines. In addition, the request does not indicate the number being dispensed. Therefore, the request for Valium is not medically necessary.

SOMA 350MG 1HS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Page(s): 29.

Decision rationale: As stated on page 29 of the California MTUS Chronic Pain Medical Treatment Guidelines, Carisoprodol is a muscle relaxant and is not recommended as it is not indicated for long-term use as well as having an active metabolite which is a schedule Intravenous (IV) controlled substance. In this case, medical records from 2013 and 2014 were not available to establish possible extenuating circumstances that would warrant the use of this unsupported medication. This medication is a scheduled substance and is not recommended for use in this patient. Therefore, the request for soma is not medically necessary.