

<b>Case Number:</b>	CM14-0023809		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	03/18/2004
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation and Pain Medicine, and is licensed to practice in Texas. 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 Physician 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 50-year-old male who reported an injury on 03/18/2004. The mechanism of injury was not specifically stated. Current diagnoses include spinal stenosis of the lumbar region, other kyphoscoliosis, post lumbar laminectomy, low back pain, sacroiliitis, facet arthropathy, and chronic pain syndrome. The injured worker was evaluated on 02/06/2014 with complaints of moderate to severe lower back pain. Current medications include gabapentin 800 mg, Norco 10/325 mg, and methadone 10 mg. Previous conservative treatment was not mentioned. Physical examination revealed an antalgic gait with intact coordination and bilateral hip pain with tenderness to palpation. Treatment recommendations at that time included continuation of current medication, sacroiliac joint injections, and a functional restoration program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **CONSULTATION FUNCTIONAL RESTORATION PROGRAM (FRP): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-33.

**Decision rationale:** The California MTUS Guidelines indicate that functional restoration programs are recommended where there is access to programs with proven successful outcomes for patients with conditions that place them at delayed recovery. There should be evidence that previous methods of treating chronic pain have been unsuccessful with an absence of other options that are likely to result in significant clinical improvement. There should also be evidence of a significant loss of the ability to function independently. Negative predictors of success should also be addressed. Total treatment duration should generally not exceed 20 full day sessions. According to the documentation submitted, there is no mention of an exhaustion of conservative treatment prior to the request for a functional restoration program. The injured worker is currently pending authorization for physical therapy and chiropractic care. The total duration of treatment was also not specified in the request. Based on the clinical information received, the request is not medically necessary.

**GABAPENTIN 800 MG, #60 X 4 REFILLS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPTIC DRUGS Page(s): 16-18.

**Decision rationale:** The California MTUS Guidelines indicate that antiepilepsy drugs are recommended for neuropathic pain. The injured worker has utilized gabapentin since 08/2013 without any evidence of objective functional improvement. There is also no frequency listed in the current request. As such, the request is not medically necessary.

**HYDROCODONE-ACETAMINOPHEN 10/325 MG, #120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines indicate that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized this medication since 08/2013 without any evidence of objective functional improvement. There is also no frequency listed in the current request. As such, the request is not medically necessary.

**METHADONE HCL 10 MG, #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61-62.

**Decision rationale:** The California MTUS Guidelines indicate that methadone is recommended as a second line drug for moderate to severe pain if the potential benefit outweighs the risk. The injured worker has utilized this medication since 12/2013 without any evidence of objective functional improvement. Therefore, continuation cannot be determined as medically appropriate. There is also no frequency listed in the current request. As such, the request is not medically necessary.

**SACROILIAC JOINT INJECTIONS BILATERAL:** 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).

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

**Decision rationale:** The Official Disability Guidelines indicate that prior to a sacroiliac joint block, the history and physical should suggest the diagnosis with at least 3 positive examination findings. There should also be evidence of a failure of at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercise, and medication management. According to the documentation submitted, the injured worker's physical examination does not reveal 3 positive examination findings. There is also no mention of an exhaustion of aggressive conservative therapy prior to the request for a sacroiliac joint block. Based on the clinical information received, the request is not medically necessary.