

<b>Case Number:</b>	CM14-0031352		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	09/09/2001
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2014

### 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 Physical Medicine & Rehabilitation 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 injured worker is a 56-year-old female who reported an injury 09/09/2001 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to her low back and bilateral knees. The injured worker's treatment history included a left total knee replacement followed by manipulation under anesthesia and postoperative physical therapy. The injured worker also underwent radiofrequency ablation at the L3-L4 on 11/12/2013. The injured worker was evaluated on 11/21/2013. The injured worker's medications were listed as Lunesta 3 mg, Zanaflex 4 mg, Norco 10/325 mg, Nucenta Extended Release 150 mg, and Methadone 5 mg. The injured worker complained of 7-9/10 neck, low back and bilateral hand pain. It was noted that the injured worker had a decrease in pain and an increase in activity due to medications. No physical evaluation was provided at this appointment. A request was made for bilateral radiofrequency ablation at the L3-L4 and a refill of medications. However, no justification for the request was provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lunesta 3 mg, QTY: 30: 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), Pain Chapter, Insomnia Treatment.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Chapter, page(s) Insomnia Treatments.

**Decision rationale:** The requested Lunesta 3 mg quantity 30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address this medication. Official Disability Guidelines recommend pharmacological interventions such as Lunesta for insomnia related to chronic pain. The clinical documentation submitted for review does not provide an adequate assessment of the patient's sleep regime to support the need for this medication. There is no documentation that the patient has failed to respond to non-pharmacological treatments and requires pharmacological intervention for insomnia related chronic pain. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request of Lunesta 3 mg quantity 30 is not medically necessary or appropriate.

**Zanaflex 4 mg, QTY: 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, page(s) 24 Page(s): 24.

**Decision rationale:** The requested Zanaflex 4 mg quantity 60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the long term use of benzodiazepines due to a high risk of physiological and psychological dependence. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 08/2013. Therefore continued use would not be indicated. Furthermore, the request as it is submitted does not specifically identify frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Zanaflex 4 mg quantity 60 is not medically necessary or appropriate.

**Norco 10/325 mg, QTY: 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (criteria for use).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, page(s) 78 Page(s): 78.

**Decision rationale:** The requested Norco 10/325 mg quantity 120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, manage side effects and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient is monitored for aberrant behavior. Additionally, although

it is not noted that the patient has increased activity due to medication usage, there is no documentation of a quantitative assessment of pain relief to support ongoing use of this medication. Furthermore the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such the requested Norco 10/325 mg quantity 120 is not medically necessary or appropriate.

**Nucynta ER 150mg, QTY: 60: 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), Pain Chapter, Tapentadol (Nucynta).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, page(s) 78 Page(s): 78.

**Decision rationale:** The requested Nucynta ER 150 mg quantity 60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, manage side effects and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient is monitored for aberrant behavior. Additionally, although it is not noted that the patient has increased activity due to medication usage, there is no documentation of a quantitative assessment of pain relief to support ongoing use of this medication. Furthermore the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such the requested Nucynta ER 150 mg quantity 60 is not medically necessary or appropriate.

**Methadone 5 mg, QTY: 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Criteria for use).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, page(s) 78 Page(s): 78.

**Decision rationale:** The requested Methadone 5 mg quantity 60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, manage side effects and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient is monitored for aberrant behavior. Additionally, although it is not noted that the patient has increased activity due to medication usage, there is no documentation of a quantitative assessment of pain relief to support ongoing use of this medication. Furthermore the request as it is submitted does not clearly identify a frequency of

treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such the requested Methadone 5 mg quantity 60 is not medically necessary or appropriate.

**Phillips 500 mg, QTY:: 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), Pain Chapter, Medical Food.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Initiating Therapy, page(s) 77 Page(s): 77.

**Decision rationale:** The requested Phillips 500 mg quantity unstated is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the prophylactic treatment of constipation when opioids are used to manage chronic pain. However, the clinical documentation fails to provide any evidence that the patient has ongoing complaints of constipation that require medical treatment. Additionally, the request as it is submitted does not provide a frequency of treatment or quantity. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Phillips 500 mg unknown quantity is not medically necessary or appropriate.

**Toradol 30 mg IM with 1 mg of Dilaudid to the left buttocks: 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), Pain Chapter, Ketorolac (Toradol).

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** The requested Toradol 30 mg IM with 1 mg of Dilaudid to the left buttocks is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address this request. Official Disability Guidelines recommend Toradol injections as an alternative to opioid usage. The clinical documentation submitted for review does not clearly identify the need for a Toradol injection. Based on the current clinical documentation, it does not appear that it is being used as an alternative to opioid therapy. The clinical documentation does not provide an adequate pain assessment of the patient to support the need for an additional injection. As such, the requested Toradol 30 mg IM with 1 mg of Dilaudid to the left buttock is not medically necessary or appropriate.

**Bilateral radiofrequency lesioning of the L3-L4 under flouroscopy with moderate sedation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low

Back -Lumbar & Thoracic Chapter (updated 10/18/2008), Facet Joint Radiofrequency neurotomy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Facet joint radiofrequency neurotomy.

**Decision rationale:** The requested bilateral radiofrequency lesioning of the L3-L4 under fluoroscopy with moderate sedation is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do not address repeat bilateral radiofrequency lesioning. Official Disability Guidelines recommend bilateral radiofrequency lesioning for patients who have had at least a 50% decrease in pain with documented functional improvement for at least 6 months. The clinical documentation does indicate that the injured worker underwent a radiofrequency ablation at the L3-L4 on 11/12/2013, however only clinical documentation submitted for review after that procedure was dated 11/21/2013 and did not address results from the previous procedure. Therefore, there was no way to determine the successfulness of the initial procedure and an additional procedure is not supported. As such, the requested bilateral radiofrequency lesioning at the L3-L4 under fluoroscopy with moderate sedation is not medically necessary or appropriate.