

<b>Case Number:</b>	CM14-0046071		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	04/23/1998
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	04/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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 62-year-old male who reported an injury on 04/23/1998 after a fall. The injured worker reportedly sustained an injury to his low back and hips. The injured worker's treatment history included chiropractic care, physical therapy, multiple medications, and a home exercise program. The injured worker also has a history of lumbar rhizotomies. The injured worker was evaluated on 03/30/2014. It was documented that the injured worker had undergone a radiofrequency ablation approximately 3 years ago with good benefit. It was noted that the injured worker's medications allowed the injured worker to manage pain levels to assist with completion of activities of daily living. The injured worker's medications included OxyContin, Percocet, Flexeril, Neurontin, Prilosec, Relafen, and Lidoderm patches. Physical findings included tenderness to palpation of the lumbar spine with decreased range of motion secondary to pain. It was noted that the injured worker had a negative straight leg raising test. The injured worker's diagnoses included chronic low back pain, bilateral hip pain, intermittent right anterior thigh pain and bilateral groin pain, chronic lumbar radiculitis, degenerative lumbar discs, sacroiliitis, and lumbar facet arthropathy responsive to radiofrequency rhizotomies. A repeat rhizotomy was being requested due to a severe exacerbation of the injured worker's chronic pain. The injured worker was also prescribed Voltaren gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg #180:** Upheld

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

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

**Decision rationale:** The requested 1 Prescription of Percocet 10/325 mg #180 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, documented functional benefit, managed 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 injured worker has a reduction in pain resulting from medication. There was no quantitative assessment of pain relief provided. Additionally, the clinical documentation fails to provide any evidence of significant functional benefit resulting from medication usage. There was no documentation that the injured worker is monitored for aberrant behavior. Therefore, ongoing use of this medication would not be indicated in this clinical situation. 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 Percocet 10/325 mg #180 is not medically necessary or appropriate.

**Bilateral L4-L5 and L5-S1 radiofrequency rhizotomy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pulsed radiofrequency treatment (PRF) and Facet joint radiofrequency neurotomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Facet joint radiofrequency neurotomy.

**Decision rationale:** The requested 1 bilateral L4-L5 and L5-S1 radiofrequency rhizotomy is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends radiofrequency ablation for the lumbar spine as an appropriate treatment option after a positive response to medial branch block. The clinical documentation does indicate that the injured worker has a history of radiofrequency rhizotomies that provide good relief of symptoms. However, Official Disability Guidelines recommend repeat radiofrequency rhizotomies be based on at least 50% pain relief and documented functional benefit and reduction of medications to support an additional radiofrequency rhizotomy. The clinical documentation submitted for review does not adequately address at what levels the previous radiofrequency rhizotomies were provided. Therefore, it is unclear if a medial branch block or a repeat radiofrequency ablation is the appropriate treatment for this injured worker. Additionally, it is noted that the injured worker received a radiofrequency rhizotomy approximately 3 years ago. However, no details of the injured worker's response to that treatment were provided. As such, the requested bilateral L4-L5 and L5-S1 radiofrequency rhizotomy is not medically necessary or appropriate.

**Voltaren gel 1% 2 gm #2 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The requested 1 prescription of Voltaren gel 1% 2 gm. #2 with 3 refills is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends non-steroidal anti-inflammatory drugs in a topical formulation when the injured worker is intolerant of oral formulations of this type of medication. Additionally, California Medical Treatment Utilization Schedule recommends short courses of treatment of this type of medication to be limited to 4 weeks. The request as it is submitted does not identify a frequency of treatment; however, there are 3 refills attached to the request. It would appear the request would exceed the 4 week treatment recommendation. Additionally, there was no documentation that the injured worker is intolerant of oral formulations of non-steroidal anti-inflammatory drugs. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Voltaren gel 1% 2 gm #2 with 3 refills is not medically necessary or appropriate.