

<b>Case Number:</b>	CM15-0000911		
<b>Date Assigned:</b>	01/12/2015	<b>Date of Injury:</b>	04/06/1999
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: New Jersey, New York  
Certification(s)/Specialty: Family Practice

### 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 male patient, who sustained an industrial injury on 04/06/1999. A primary treating office visit dated 12/10/2014 reported osteoarthritis of knee and lumbar spondylosis. The chief complaint noted with chronic bilateral lower back pain. The pain is described as aching, dull and constant. The pain is aggravated by carrying, standing and or walking. Medications and rest offer some relief. Radiography 11/08/2000 of bilateral knees found right knee joint space caliber normal with an ovoid benign appearing sclerosis at the anterior metafacial area of the tibia; left knee alignment and joint space normal with minimal degenerative lipping at the medical and superior articulating margin of the patella. Her surgical history is as follows; 1994 Right open knee times two, 1990 left knee arthroscopy, and 1989 shoulder Mumford procedure. She is prescribed Hydrocodone/Acetaminophen 5/325 MG. she is diagnosed with lumbosacral spondylosis without myelopathy, osteoarthritis of right knee. On 12/23/2014 Utilization Review non-certified the request for medication Hydrocodone/Acetaminophen, noting the CA MTUS opioids, use, discontinuing and facet joint injection are cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 5/325mg #90 with two refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone-acetaminophen and Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-79.

**Decision rationale:** The request is considered not medically necessary. The patient has been on opiates for unclear amount of time without significant objective documentation of the improvement in pain. There is no documentation of the four A's of ongoing monitoring: pain relief, side effects, physical and psychosocial functioning, and aberrant drug-related behaviors. There was no drug contract documented. There are no clear plans for future weaning, or goals of care. The patient should have been weaned by now. Because of these reasons, the request for hydrocodone is considered medically unnecessary.

**Radiofrequency ablation bilaterally at L4-5 and L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Lower Back, Facet joint radiofrequency neurotomy

**Decision rationale:** The request is considered not medically necessary. The use of facet joint radiofrequency neurotomy is largely under study according to ODG guidelines. MTUS does not give specific guidelines regarding radiofrequency ablation. The patient has not had facet joint diagnostic blocks. The use of radiofrequency ablation shows conflicting evidence regarding the efficacy and while there have been demonstrations of decreased pain temporarily, there have been no demonstrations of increased function. Because of the lack of definitive evidence, this request is considered not medically necessary.