

<b>Case Number:</b>	CM15-0004178		
<b>Date Assigned:</b>	01/15/2015	<b>Date of Injury:</b>	08/31/2007
<b>Decision Date:</b>	03/20/2015	<b>UR Denial Date:</b>	01/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 51-year-old male who reported an injury on 08/31/2007 after an object weighing approximately 700 to 800 pounds collapsed onto the injured worker's abdomen. The injured worker's treatment history included physical therapy, multiple medications, and epidural steroid injections. The injured worker was evaluated on 12/15/2014. The injured worker's medications included Anaprox DS 550 mg and Norco 10/325 mg. It was noted that the injured worker had 9.5/10 pain on a VAS. Physical exam findings included restriction range of motion of the lumbar spine with decreased sensation over the right L3, L4, L5, and S1 dermatomal distribution with tenderness to palpation over the midline lower lumbar spine. The injured worker's diagnoses included disc degeneration of facet arthropathy at the L2-S1 and left L5 radiculopathy. The injured worker's treatment plan included a pain management consultation for L4-5 and L5-S1 facet blocks and continuation of medications. A prescription for Restoril was provided. A Request for Authorization was submitted on 12/15/2014 to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain Management Consultation and left sided L4-5 & L5-S1 Facet Blocks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 503 and ODG, Treatment Index, 11th Edition (web), 2014, Pain, Office Visits, Low Back, Facet Joint pain, signs & symptoms

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) 7, page(s) 124.

**Decision rationale:** The requested pain management consultation and left sided L4-5 & L5-S1 facet blocks is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do recommend specialty consultations to assist with diagnosing and treatment planning of complicated diagnoses. The clinical documentation submitted for review does indicate that the injured worker has a complicated diagnoses. The treatment plan indicates that the request for pain management consultation is in an attempt to avoid surgical intervention. This would be supported in this clinical situation. However, the request includes left sided L4-5 and L5-S1 facet blocks. Without evaluation from the pain management physician, the need for left sided L4-5 and L5-S1 facet blocks cannot be determined. As such, the requested pain management consultation and left sided L4-5 and L5-S1 facet blocks are not medically necessary or appropriate.

**Anaprox 550mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60, 67.

**Decision rationale:** The request for Anaprox 550mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of nonsteroidal anti-inflammatory drugs to assist in the management of chronic pain. However, the clinical documentation fails to provide any evidence that the injured worker has significant pain relief or functional increase resulting from the use of this medication. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of use. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Anaprox 550mg #60 is not medically necessary or appropriate.

**Norco 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

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

**Decision rationale:** The requested Norco 10/325mg #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 documented functional benefit, evidence of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not indicate that the injured worker receives significant pain relief or functional benefit resulting from the use of this medication. Furthermore, there is no indication that the injured worker is monitored for aberrant behavior. Additionally, the request as it is submitted does not clearly identify a frequency of use. In the absence of this information, the appropriateness of the request itself cannot be determined.

**Restoril 30mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia Treatments.

**Decision rationale:** The requested Restoril 30mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend pharmacological interventions for insomnia related to chronic pain when the injured worker has failed to respond to non pharmacological interventions. An adequate assessment of the injured worker's sleep patterns was not provided to support the need for pharmacological intervention. There is no documentation that the injured worker has failed to respond to non pharmacological treatments. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Restoril 30mg #30 is not medically necessary or appropriate.