

Case Number:	CM15-0202266		
Date Assigned:	10/19/2015	Date of Injury:	08/09/1998
Decision Date:	12/22/2015	UR Denial Date:	10/14/2015
Priority:	Standard	Application Received:	10/14/2015

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: Preventive Medicine, Occupational 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:

This is a 73 year old male with a date of injury of August 9, 1998. A review of the medical records indicates that the injured worker is undergoing treatment for radial styloid tenosynovitis, carpal tunnel syndrome, lumbosacral spondylosis without myelopathy, and lumbar strain. Medical records dated June 22, 2015 indicate that the injured worker complained of recent flare up of back pain. A progress note dated August 10, 2015 documented complaints similar to those reported on June 22, 2015. Per the treating physician (August 10, 2015), the employee was retired. The physical exam dated June 22, 2015 reveals tenderness to the right side of the back at L4-5 and L5-S1, and tenderness of the facet joints with flexion. The progress note dated August 10, 2015 documented a physical examination that showed no changes since the examination performed on June 22, 2015. Treatment has included medications (Norco and Trazodone since at least July of 2014), and magnetic resonance imaging of the lumbar spine (no date provided) that showed multilevel degenerative changes. The physician did not document results of recent urine drug screens. The original utilization review (October 14, 2015) non-certified a request for Trazodone 50mg, cortisone injection with ultrasound and fluoroscopy, and range of motion-manual muscle testing, and partially certified a request for Norco 10-325mg #60 to allow for weaning (original request for Norco 10-325mg).

IMR ISSUES, DECISIONS AND RATIONALES

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

RFA Cortisone injection with ultrasound and fluoroscopy: 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) (http://www.odg-twc.com/odgtwc/low_back.htm).

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 - Lumbar & Thoracic (Acute & Chronic), Facet joint radiofrequency neurotomy.

Decision rationale: According to the Official Disability Guidelines, the criteria for use of facet joint radiofrequency neurotomy requires a diagnosis of facet joint pain using a medial branch block, and facet joint medial branch blocks are not recommended except as a diagnostic tool. There is minimal evidence to support their use as treatment. RFA Cortisone injection with ultrasound and fluoroscopy is not medically necessary.

Trazodone 50mg: 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), Trazodone.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Antidepressants for chronic pain.

Decision rationale: Trazodone is a tetracyclic antidepressant used to treat depression and anxiety disorders. The Official Disability Guidelines recommend numerous antidepressants in a number of classes for treating depression and chronic pain. Trazodone is not contained within the current recommendations by the ODG. The documentation for review had no specific indications that would warrant the use of Trazodone. Trazodone 50mg is not medically necessary.

Norco 10/325: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. A

previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. Norco 10/325 is not medically necessary.

ROM/ MMT testing (DOS 08/10/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Summary. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy, Quantitative Muscle Testing Devices, Document Number MED.00089, Last Review Date: 11/14/2013.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines do not address quantitative muscle testing devices; consequently, alternative guidelines were used. According to the Blue Cross of California Medical Policy, Quantitative Muscle Testing Devices, Document Number MED.00089, use of quantitative muscle testing devices is considered investigational and not medically necessary. Quantitative muscle testing has been used in clinical research to quantify muscle strength and an individual's response to rehabilitation and therapy. However, manual muscle testing is sufficiently reliable for clinical practice. There is insufficient peer-reviewed published scientific evidence that quantitative muscle testing is superior. In addition, the ACOEM Guidelines Summaries of Recommendations and Evidence Tables do not support quantitative muscle testing for any muscle group. ROM/ MMT testing (DOS 08/10/2015) is not medically necessary.