

<b>Case Number:</b>	CM15-0035808		
<b>Date Assigned:</b>	03/04/2015	<b>Date of Injury:</b>	06/02/2011
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	02/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2015

### 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, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 54 year old female who sustained an industrial injury on 6/2/11. The injured worker reported symptoms in the back and lower extremities. The diagnoses included chronic pain syndrome, thoracic or lumbosacral neuritis or radiculitis, unspecified, degeneration of lumbar or lumbosacral intervertebral disc, lumbago, lumbar facet joint pain and post-traumatic stress disorder. Treatments to date include oral pain medications, heat/ice application, activity modification, and home exercise. In a progress note dated 5/30/14 the treating provider reports the injured worker was with "continued tenderness and tightness across the lumbosacral area left more than right." On 2/25/15 Utilization Review non-certified the request for a left L5-S1 radiofrequency rhizotomy #1, modified Norco 10/325 milligrams #120 to Norco 10/325 milligrams #108, modified Xanax 0.5 milligrams #60 to Xanax 0.5 milligrams #54, and non-certified Robaxin 750 milligrams #90. The MTUS, ACOEM Guidelines, (or ODG) was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L5-S1 radiofrequency rhizotomy #1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines 3rd Edition 2011 Low back Disorders page 619.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Facet joint intra-articular injections (therapeutic blocks) ([http://worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#Facetjointinjections](http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections)).

**Decision rationale:** According MTUS guidelines, "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain." According to ODG guidelines regarding facets injections, "Under study: Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial." Furthermore and according to ODG guidelines, "Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection." According to MTUS guidelines, "there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief of pain. Similar quality literature does not exist regarding the same procedure in the lumbar region. Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks." There is no documentation of pain relief and functional improvement from the April 1, 2014 and August 18, 2014 left L5-S1 medial branch facet injection under fluoroscopy guidance. Therefore, the request for Left L5-S1 radiofrequency rhizotomy #1 is not medically necessary.

**Norco 10/325mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

**Decision rationale:** According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: "(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework." According to the patient file, there is no objective documentation of pain and functional improvement to justify continuous use of Norco. Norco was used for longtime without documentation of functional improvement or evidence of return to work or improvement of activity of daily living. Therefore, the prescription of Norco 10/325mg #120 is not medically necessary.

**Xanax 0.5mg #60:** Upheld

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

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

**Decision rationale:** Benzodiazepines are not recommended for long term use for pain management because of unproven long term efficacy and because of the risk of dependence. Most guidelines limit their use to 4 weeks. There is no recent documentation of insomnia related to pain. The patient has been taking Xanax without documentation of improvement. Therefore, the use of Xanax 0.5mg #60 is not medically necessary.

**Robaxin 750mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** According to MTUS guidelines, Robaxin, a non sedating muscle relaxants, is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient in this case does not have clear recent evidence of spasm or that she was experiencing an acute exacerbation of pain. There is no clear documentation of the efficacy of previous use of Robaxin (the patient had been prescribed Robaxin on an ongoing basis for long time). The request for Robaxin 750mg #90 is not medically necessary.