

Case Number:	CM15-0088903		
Date Assigned:	05/13/2015	Date of Injury:	12/20/1996
Decision Date:	06/15/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/08/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 64-year-old male who sustained an industrial injury on 12/20/96. Past medical history was positive for diabetes type 2, asthma, and hypertension. Past surgical history was positive for two back surgeries (not specified). The injured worker underwent left L2-5 and right L2, L3, and L5 radiofrequency ablations on 7/15/14. The 7/28/14 treating physician report documented a 50% reduction in pain with continued sharp pain on the right. The treatment plan included prescription of hydrocodone/acetaminophen 7.5/325 mg #60 with 2 refills, and Flector patches one daily with 2 refills. The 10/20/14 treating physician report documented current pain grades, general activity, and quality of life levels consistent with those documented on 6/2/14, prior to radiofrequency ablation. The treatment plan included two prescriptions of hydrocodone/acetaminophen 7.5/325 mg #80, increased from twice a day to three times per day. The 4/6/15 treating physician report cited chronic low back pain worse with standing and twisting. He had done some physical therapy and swimming with some success. He had been on Norco 7.5 mg, but was on a little more before. He was status post right L2-5 and left L2, L3, and L5 radiofrequency ablation in July 2014. He was feeling that pain was coming back now, with sharp pain on the right probably at the area where his disc space was coming out. The injured worker was interested in injections and consideration of epidural steroid injection at left L4/5 and L5/S1 was noted. Physical exam documented intact heel/toe walk, 5/5 lower extremity strength, negative straight leg raise, and limited lumbar range of motion with pain on extension and lateral rotation. There was general lumbar tenderness to palpation documented. Reflexes were symmetric. The diagnosis was lumbar spondylosis and post-laminectomy syndrome. The treatment plan included

a request for radiofrequency ablation to left L2, L3 and L4, and right L2- L5, and two prescriptions of hydrocodone/acetaminophen 7.5/325 mg #80. The 4/24/15 utilization review non-certified the request for radiofrequency ablation to left L2, L3 and L4, and right L2-L5 based on an absence of adequate evidence of sustained pain relief, functional improvement, and decreased medication use following the prior radiofrequency ablation in July 2014. Additionally, the requested treatment included more than 2 levels and there was no evidence of a formal plan of on-going evidence-based conservative care. The request for one prescription of hydrocodone/acetaminophen 7.5/325 mg #80 was modified to hydrocodone/ acetaminophen 7.5/325 mg #60 to allow for weaning and discontinuation based on an absence of significant functional improvement associated with use. The request for one additional prescription of hydrocodone/acetaminophen 7.5/325 mg #80 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency (RFA) to left L2, L3, and L4 and right L2-L5: 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), (updated 04/15/15).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic, Facet joint diagnostic blocks (injections); Facet joint radiofrequency neurotomy.

Decision rationale: The California MTUS guidelines state that facet neurotomies are under study and should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The Official Disability Guidelines indicate that facet joint radiofrequency ablation (neurotomy, rhizotomy) is under study. Criteria state that neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications, and documented improvement in function. There should be evidence of a formal plan of additional evidenced based conservative care in addition to facet joint therapy. The ODG do not recommended facet joint diagnostic blocks for patients with radicular low back pain or patients who have had prior fusion at the planned injection level. Guideline criteria have not been met. This patient presents with status post prior lumbar surgery with report that a disc space was out of place. He underwent radiofrequency ablation at the requested levels on 7/16/14 with initial 50% pain reduction and functional improvement noted on 7/28/14 with return to pre-injection levels as of 10/20/14. There was no specific evidence of pain medication reduction or sustained pain relief for at least 6 months. Additionally, records would suggest that the injured worker is status post interbody fusion at L4/5. Given the failure to meet guideline criteria relative to sustained benefit and decreased medications, and the apparent

contraindication of prior fusion at one of the requested levels, this request is not medically necessary.

Hydrocodone/Acetaminophen 7.5/325mg #80: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Opioids, specific drug list Page(s): 76-80, 91.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines support the use of hydrocodone/acetaminophen for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. Guideline criteria have not been met. This injured worker has been prescribed hydrocodone/acetaminophen 7.5/325 mg since at least 7/28/14 with no specific evidence of pain reduction, increased function, or improved quality of life relative to medication use. The 4/24/15 utilization review modified the request for one prescription of hydrocodone/acetaminophen 7.5/325 mg #80 to hydrocodone/acetaminophen 7.5/325 mg #60 to allow for weaning and discontinuation based on an absence of significant functional improvement associated with use. There is no compelling rationale in the file to support the on-going use of this medication in the absence of specific objective functional improvement associated with use. Therefore, this request is not medically necessary.

Hydrocodone/Acetaminophen 7.5/325mg #80: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Opioids, specific drug list Page(s): 76-80, 91.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines support the use of hydrocodone/acetaminophen for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. Guideline criteria have not been met. This injured worker has been prescribed hydrocodone/acetaminophen 7.5/325 mg since at least 7/28/14 with no specific evidence of pain reduction, increased function, or improved quality of life relative to medication

use. The 4/24/15 utilization review modified the request for one prescription of hydrocodone/acetaminophen 7.5/325 mg #80 to hydrocodone/acetaminophen 7.5/325 mg #60 to allow for weaning and discontinuation based on an absence of significant functional improvement associated with use. There is no compelling rationale in the file to support the on-going use of this medication in the absence of specific objective functional improvement associated with use. Therefore, this request is not medically necessary. Prescription of an additional amount of hydrocodone/acetaminophen is not supported based on the discussion noted above and in the absence of specific objective functional improvement. Therefore, this request for a second prescription of hydrocodone/acetaminophen is not medically necessary.