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| <b>Case Number:</b>   | CM14-0121518 |                              |            |
| <b>Date Assigned:</b> | 08/06/2014   | <b>Date of Injury:</b>       | 10/23/2007 |
| <b>Decision Date:</b> | 10/08/2014   | <b>UR Denial Date:</b>       | 07/16/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/01/2014 |

### 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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 worker is a 59-year-old female who was injured on October 23, 2007. She was diagnosed with lumbosacral disc degeneration, right ankle/foot sprain/strain/plantar fasciitis/plantar fibroma, right shoulder sprain, right shoulder impingement syndrome, lumbar spondylolisthesis, left foot sprain/plantar fasciitis, rheumatoid arthritis, osteoarthritis, bilateral carpal tunnel syndrome, cervical radiculopathy, and coccygeal contusion with coccygodyria. She was treated with oral medications including benzodiazepines, opioids, topical analgesics, NSAIDs, and muscle relaxants, physical therapy, joint injections, wrist splint, surgery (right foot), and lumbar radiofrequency ablation (L5, S1 medial branches bilaterally). On February 20, 2014, the worker was prescribed "a small prescription" of Xanax to "take for severe anxiety", Zanaflex to take at night to help relieve her muscle spasms in her lower back, and increase her Norco frequency all due to increased pain reported to her primary treating physician that day. On July 8, 2014, the worker was seen by her primary treating physician (orthopedic surgeon) complaining to have right shoulder pain, lower back pain, numbness in her left forearm/wrist/hand and right wrist/hand, and feet pain. She reported taking Lunesta, Flector patches, Norco, Pennsaid solution, and Anaprox. Another radio frequency ablation from L4-S1 bilaterally was requested. She was also prescribed refills on her medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco (10/325mg, #150 with 1-refill): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/acetaminophen: Opioids, criteria for use and Weaning o.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that opioids may be recommended for chronic back pain, and might be efficacious for some, but studies are limited for long-term use. In order to justify continuation of any opioid, guidelines require that the worker was indeed returned to work, and if the patient has improved functioning and pain as a result of its use. In the case of this worker, there is no record found in the notes provided for review of the worker's functional improvement related to Norco use, and no up to date evaluation of its pain reduction effect on the worker. Therefore, without this documentation, the request is not medically necessary.

**Zanaflex (4mg, #30 with 3-refills): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (FOR PAIN) AND Tizanidine (zanaflex).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that muscle relaxants may be recommended as a second-line option for short-term treatment of acute exacerbations of chronic low back pain, but do not seem to show any benefit beyond NSAIDs in pain and overall improvement. In the case of this worker, She had been using Zanaflex for months leading up to this request, which is much longer than recommended for this type of medication. Also, no evidence suggested that this request for a refill of Zanaflex was intended to treat an short-term acute exacerbation. Therefore, the Zanaflex is not medically necessary.

**Xanax (0.5mg, #40 with 1-refill): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 402.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. In the case of this worker, the prescribing physician seemed to intend for the Xanax prescribed months ago to be short, but it continued to be refilled longer than recommended for what seemed to be a temporary anxiety. Without a clear and warranted indication for its continuation, the request is not medically necessary.

**One lumbar radiofrequency ablation at bilateral L4, L5 and 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:** 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 section, Facet joint radiofrequency neurotomy

**Decision rationale:** The ACOEM Practice Guidelines state that there is good quality evidence that neurotomy of facet joints in the cervical spine is effective, however, similar evidence does not exist for the same procedure on the lumbar spine, and they tend to produce variable results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The Official Disability Guidelines supply a more complete criteria list for justifying a lumbar facet joint radiofrequency neurotomy: 1. Diagnosis of facet joint pain (via medial branch block), 2. No more than 3 procedures performed in a given year, 3. Documented improvement in pain (>50% for at least 12 weeks) if repeat procedure is requested, 4. No more than 2 joint levels at a time, 5. If two areas need the procedure than space them by at least 1-2 weeks, and 6. Evidence of a formal plan of additional conservative care to be used in addition to the procedure. In the case of this worker, the requested ablation therapy included three joint levels, when only 1-2 levels is recommended for this procedure at one time. Therefore, the bilateral ablation for levels L4, L5, and S1 is not medically necessary.