

Case Number:	CM14-0214584		
Date Assigned:	01/07/2015	Date of Injury:	01/21/2000
Decision Date:	02/24/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/22/2014

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. 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 patient is a 57 year old employee with date of injury of 1/21/200. Medical records indicate the patient is undergoing treatment for chronic low back pain with lumbar DDD with radiculopathy. Subjective complaints include pain in the left leg, gluteus and hip. He has a new pain that now radiates to his left big toe. He has had recent rhizotomys that were 70% effective in pain reduction. However, his pain is now increasing and affecting his ability to complete acts of daily living. The pain is causing insomnia. His pain level is 7/10 without medication and 2-3/10 with medication. Past rhizotomys have allowed the patient to decrease his use of pain medications. Objective findings include on exam: full cervical ROM; lumbar spine is tender and tight across lumbosacral area with 10 degrees extension; pain in low back that radiates to left big toe; normal flexion; left positive Patrick's and tenderness and pain with left lateral bending. MRI of lumbar spine (11/2013) revealed multilevel degenerative disc bulging from L1-2 down to L4-S1. Facet osteoarthritis throughout lumbar spine. Forminal narrowing bilaterally at L3-L4 and L4-S1. Treatment has consisted of Norco, multiple rhizotomys, Ibuprofen, Benzapril and physical therapy. The utilization review determination was rendered on 12/4/2014 recommending non-certification of Norco and L4, L5 Sacral ALA S1 Rhizotomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg quantity 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): (s) 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines; Low Back - Lumbar & Thoracic (Acute & Chronic), Pain, Opioids

Decision rationale: ODG does not recommend the use of opioids for low back pain except for short use for severe cases, not to exceed 2 weeks. The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. Additionally, medical documents indicate that the patient has been on Norco for several months which are in excess of the recommended 2-week limit. As such, the question for Norco 10/325 mg quantity 60 is not medically necessary.

Bilateral L4, L5 sacral ALA S1 radio frequency rhizotomy: 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); Rhizotomy, Lumbar Facet Joint Radiofrequency Neurotomy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines; Low Back, Facet Joint Radiofrequency Neurotomy.

Decision rationale: ODG states, Criteria for use of facet joint radiofrequency neurotomy: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections). (2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A 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. (3) 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. (4) No more than two joint levels are to be performed at one time. (5) If different regions require

neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. (6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. ODG indicates that Rhizotomy is still under study and conflicting information exist in the medical literature. The patient has a positive straight leg raise test, which can indicate radiculopathy and there is no documentation of facet joint pain. Radiculopathy is a contraindication for facet joint pain. The treating physician has not met the above guidelines at this time. As such, the request for Bilateral L4, L5 sacral ALA S1 radio frequency rhizotomy is not medically necessary.