

Case Number:	CM15-0014599		
Date Assigned:	02/02/2015	Date of Injury:	07/21/2005
Decision Date:	03/30/2015	UR Denial Date:	01/17/2015
Priority:	Standard	Application Received:	01/26/2015

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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 58-year-old male who reported an injury on 07/21/2005. The mechanism of injury was not provided. His diagnoses were noted as low back pain, spinal/lumbar degenerative disc disease, lumbar radiculopathy, and lumbar facet syndrome. His past treatments were noted to include medication, physical therapy, home exercise program, a cane, a radiofrequency ablation, and activity modification. His diagnostic studies were not provided. His surgical history was not provided. During the assessment on 02/05/2015, the injured worker complained of increased lower backache. He rated his pain with medications a 5/10 and a 9/10 without medications. He indicated that he had increased pain and withdrawal, as he did not receive any of his medications the month prior. The physical examination of the lumbar spine revealed restricted range of motion with pain. There was tenderness to palpation of the paravertebral muscles, hyper tonicity, spasm was noted bilaterally. The lumbar facet loading was positive bilaterally. There was tenderness noted over the coccyx. There was a positive straight leg raise test on the left side. His medication was noted to include baclofen 10 mg, Avinza 90 mg, Lidoderm 5% patch, and Norco 10/325 mg. The treatment plan and rationale for the request was not provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Norco 10/325 mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco, Opioids, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, on-going management Page(s): 78.

Decision rationale: The request for 1 prescription of Norco 10/325 mg #150 is not medically necessary. The California MTUS Guidelines state that ongoing management of opioid use should include documentation of pain relief, functional status, side effects, and appropriate medication use with the use of random drug screen as needed to verify compliance. The guidelines specify that an adequate pain assessment should include the current pain level, the least reported pain over the period since the last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, and how long the pain relief lasts. There was a lack of documentation regarding adverse effects and evidence of consistent results on urine drug screens to verify appropriate medication use. Additionally, the frequency was not provided. Given the above, the request is not medically necessary.

1 Radiofrequency Ablation At Bilateral L3-4, Bilateral L4-5 and Bilateral L5-S1-: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. 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): 301.

Decision rationale: The request for 1 radiofrequency ablation at bilateral L3-4, bilateral L4-5, and bilateral L5-S1- is not medically necessary. The California MTUS/ACOEM Guidelines indicate that there is good quality medical literature demonstrating that radiofrequency neurotomy of facet joint nerves in the cervical spine provides good temporary relief for 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. The clinical documentation did not indicate that medial branch diagnostic blocks were performed prior to the request. Furthermore, the guidelines indicate that facet neurotomies in the lumbar region produce mixed results. Furthermore, the rationale for the request was not provided. Given the above, the request is not medically necessary.