

Case Number:	CM14-0147819		
Date Assigned:	09/15/2014	Date of Injury:	04/25/1988
Decision Date:	10/22/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/11/2014

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 Emergency Medicine and is licensed to practice in Texas. 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 injured worker is a 52-year-old male who reported an injury on 04/25/1988 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his low back that ultimately resulted in L4-5 fusion. The injured worker's postsurgical pain was managed with medications and radiofrequency ablations. The injured worker was evaluated on 05/29/2014. It was documented that the injured worker had undergone a radiofrequency ablation with good results and would undergo an additional ablation in 09/2014. It was documented that the patient had increased activity level secondary to the radiofrequency ablation. Physical findings included restricted range of motion secondary to pain with moderate tenderness over the right L5-S1, L4-5, L3-4, and L2-3 levels. The injured worker's diagnoses included lumbar disc injury, disc facet arthralgia, bilateral sciatica, L5-S1 fusion, and bilateral radiculopathy. The injured worker's treatment plan included a refill of medications and a Toradol injection. A Letter of Appeal, dated 09/04/2014, documented that a radiofrequency ablation request received an adverse determination, as the patient previously underwent fusion at a requested level. No Request for Authorization form was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Lumbar Radiofrequency Neurotomy L2-3, L3-4, L4-5, L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Facet joint radiofrequency neurotomy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Facet joint radiofrequency neurotomy

Decision rationale: The requested Bilateral Lumbar Radiofrequency Neurotomy L2-3, L3-4, L4-5, L5-S1 is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends radiofrequency ablation at no more than 2 medial branch block levels. The request, as it is submitted, is for 3 levels. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Furthermore, Official Disability Guidelines further elaborate that patients who have undergone a fusion are excluded from radiofrequency ablations. The clinical documentation does indicate that the patient previously underwent a fusion at L5-S1. Therefore, radiofrequency ablation would not be appropriate at this level. As such, the requested Bilateral Lumbar Radiofrequency Neurotomy L2-3, L3-4, L4-5, L5-S1 is not medically necessary or appropriate.

Percocet 5 mg: Upheld

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

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

Decision rationale: The requested Percocet 5 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence of functional benefit related to medication usage. There is no documentation of a quantitative assessment of pain relief to support efficacy of this medication. Additionally, there is no documentation that the patient is monitored for aberrant behavior. Furthermore, the request, as it is submitted, does not clearly identify a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Percocet 5 mg is not medically necessary or appropriate.

Soma 350 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

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

Decision rationale: The requested Soma 350 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the use of muscle relaxants in the management of chronic pain. California Medical Treatment Utilization Schedule recommends the use of these medications be limited to 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation does indicate that the patient has been on this medication since at least 05/2014. This exceeds guideline recommendations. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Therefore, continued use of this medication would not be supported. Furthermore, the request, as it is submitted, does not clearly identify a frequency of treatment or quantity. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Soma 350 mg is not medically necessary or appropriate.

Toradol 60 mg IM: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (<http://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?id+710#nlnm34067-9>) Adult patients: Ketorolac tromethamine

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Toradol

Decision rationale: The requested Toradol 60 mg IM is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address Toradol injections. The Official Disability Guidelines recommend Toradol injections for reducing pain levels and opioid usage. The clinical documentation submitted for review does not provide any evidence that the patient has had a significant increase in pain that would require a Toradol injection. Additionally, there is no documentation that the patient will reduce opioid intake resulting from the use of this injection. As such, the requested Toradol 60 mg IM is not medically necessary or appropriate.