

Case Number:	CM13-0019824		
Date Assigned:	10/11/2013	Date of Injury:	04/17/2006
Decision Date:	05/08/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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 Physician 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:

This patient is a 58-year-old male with date of injury of 04/17/2006. According to the treating physician's report 08/15/2013, patient presents with severe low back pain, constant aching, spasms, 8/10 in intensity. There is no evidence of lumbar radiculopathy and the patient had positive relief with prior radiofrequency with 75% relief for more than 6 months. Listed diagnoses are: 1. Lumbar spondylosis without myelopathy. 2. Bilateral lumbar facet syndrome. 3. Mechanical low back pain. 4. Status post diagnostic lumbar facet injection with positive results. 5. Failed conservative care for pain control. Recommendation was for repeat RF ablation of bilateral lumbar facet neurotomy at L3-L4, L4-L5 levels. The patient was to continue Norco and MS Contin and Soma. Examination showed bilateral lumbar facet tenderness at L3-L4, L4-L5. Review of the reports showed that the patient had lumbar transforaminal epidural steroid injections on 01/30/2013 and 06/13/2013. There is an operative report for radiofrequency ablation, right lumbar facet joints at L3-L4, L4-L5 on 10/23/2012, on the right side and 10/09/2012 for the left side.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL RADIOFREQUENCY LUMBAR FACET NEUROTOMY (MEDIAL BRANCH NEUROTOMY) AT L3-L4 AND L4-L5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation THE OFFICIAL DISABILITY GUIDELINES, LOW BACK PAIN (ACUTE & CHRONIC)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) ODG GUIDELINES ON RF ABLATION, LUMBAR SPINE

Decision rationale: This employee presents with chronic low back pain. There is a request for bilateral lumbar radiofrequency ablation. The treating physician reports, based on his recollection on his report 08/15/2013, that the employee has significant reduction of pain following the prior radiofrequency ablation with medication reduction. However, review of the reports shows that the employee did not experience any reduction of pain following the prior radiofrequency ablation treatments. Bilateral radiofrequency ablation treatments were performed on 10/09/2012 and 10/23/2012. By 11/08/2012, the employee was still reporting 8/10 pain without use of medication, limited range of motion, tenderness to palpation examination, reduced range of motion. The treating physician's recollection of how this procedure helped is not verified by the actual documentation progress reports following the procedure. A 01/08/2013 report which is several months following the procedure would show that the employee's pain level is still at 8/10. The employee's medications are still at 5 to 6 Norco per day. A 03/12/2013 report also shows that the employee's pain level is at 8/10. This is in direct contrast to the treating physician's contention that the employee experienced reduction of pain lasting 8 months. MTUS Guidelines do not discuss RF ablation but ODG Guidelines do not recommend repeating radiofrequency ablation without documentation of pain reduction and functional improvement as well as reduction and use of medications. In this case, review of the reports shows that radiofrequency ablation treatments from October 2012 did not result in pain reduction, did not result in reduction of medication use, and that the employee continues to experience 8/10 intensity of pain. Recommendation is for denial.

PRESCRIPTION FOR SOMA 350MG 1 TAB 3X DAILY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL (SOMA®).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL (SOMA®) Page(s): 29.

Decision rationale: This employee presents with chronic low back pain and there is a prescription for Soma to be taken 3 times daily. The MTUS Guidelines do not support Soma on a chronic basis for chronic pain. In this case, the prescription for Soma is continued on a monthly basis and appears to be prescribed on a chronic basis. Given the lack of support from MTUS Guidelines, recommendation is for denial.

PRESCRIPTION FOR NORCO 10/325MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines USE OF OPIOIDS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LONG-TERM OPIOIDS USE Page(s): 88-89.

Decision rationale: This employee presents with chronic low back pain. There is a request for Norco 10/325. Progress reports were reviewed dating back to 11/08/2012 through 08/15/2013. None of the reports describes before and after pain scales with the use of this medication. There are no functional changes associated with use of chronic opiates. There are no specific mentions of significant activities of daily living, changes attributed to use of chronic opiates. There are no discussions regarding adverse side effects and aberrant behavior such as CURES report or urine drug screen. The MTUS Guidelines provide clear guidance regarding chronic use of opiates. It requires documentation of the 4 A's (analgesia, ADLs, adverse effects, and aberrant behavior). Outcome measures are required including least pain level, average pain level, time it takes for medication to work, and duration of pain relief with use of medication. Use of numeric scale is required at least once every six months to denote patient's function. In this case, none of this information is provided. Recommendation is for denial and slow weaning of the medication per MTUS.

PRESCRIPTION FOR MORPHINE SULFATE EXTENDED RELEASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LONG-TERM OPIOID USE Page(s): 88-89.

Decision rationale: This employee presents with chronic low back pain. There is a request for morphine sulfate extended release. Progress reports were reviewed dating back to 11/08/2012 through 08/15/2013. None of the reports describes before and after pain scales with the use of this medication. There are no functional changes associated with use of chronic opiates. There are no specific mentions of significant activities of daily living, changes attributed to use of chronic opiates. There are no discussions regarding adverse side effects and aberrant behavior such as CURES report or urine drug screen. The MTUS Guidelines provide clear guidance regarding chronic use of opiates. It requires documentation of the 4 A's (analgesia, ADLs, adverse effects, and aberrant behavior). Outcome measures are required including least pain level, average pain level, time it takes for medication to work, and duration of pain relief with use of medication. Use of numeric scale is required at least once every six months to denote patient's function. In this case, none of this information is provided. Recommendation is for denial and slow weaning of the medication per MTUS.