MAXIMUS Federal Services

Case Number:	CM13-0043647		
Date Assigned:	12/27/2013	Date of Injury:	07/24/2002
Decision Date:	03/05/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/24/2013

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 Orthopedic Surgery 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:

The patient is a 61 year old female who reported an injury on 07/24/2002 due to a bending motion that caused injury to her low back that ultimately resulted in spinal fusion at the L3-S1 levels. The patient's postsurgical chronic pain was managed with oral medications. The patient underwent a radiofrequency ablation in 01/2013 at the L1,L2 that provided 80% to 100% relief of low back pain for over 6 months. The patient's most recent clinical findings included returning pain rated at a 6/10 to 9/10 with a positive facet loading test and tenderness to palpation over the left and right lumbar facets. The patient's diagnoses included chronic pain syndrome, postlaminectomy syndrome of the lumbar region, obesity, lumbosacral spondylosis without myelopathy and degeneration of the lumbosacral intervertebral discs. The patient's treatment plan included; continuation of medications and a radiofrequency ablation at the L1,L2 and right L2,L3.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat Radiofrequency Lesioning of Medial Branches Left L1, L2, and Right L2-L3: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),Low Back Chapter, Facet Joint Radiofrequency Neurotomy

Decision rationale: The requested repeat radiofrequency lesioning of medial branches left L1, L2 and right L2, L3 is medically necessary and appropriate. The clinical documentation submitted for review does indicate that the patient underwent radiofrequency ablation in 01/2013. The clinical documentation does provide evidence that the patient was able to reduce her medication usage to no medications at all with pain relief at 80% to 100% for 6 to 8 months that allowed the patient to increase her functional capabilities. The American College of Occupational and Environmental Medicine do recommend radiofrequency neurotomy for patients with chronic low back pain. The clinical documentation submitted for review does indicate that the patient has chronic low back pain that was successfully treated with a previous facet joint neurotomy. Official Disability Guidelines recommend repeat neurotomies based on at least 50% pain relief, documentation of improvement of pain, decrease medications and improvement in functionality. The clinical documentation submitted for review does provide evidence that the patient had 80% to 100% pain relief for 6 to 8 months which completely eliminated her need for medication usage and allowed her to more actively participate in activities of daily living. As such, the requested repeat radiofrequency lesioning of the medial branches of the left L1, L2 and right L2, L3 is medically necessary and appropriate.

Pharmacy Purchase of Ultram 50mg #90, refills 1: 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),Treatment in Worker's Compensation, 2013, web-based edition

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

Decision rationale: The pharmacy purchase of Ultram 50 mg #90 refill 1 is not medically necessary or appropriate. In the California Medical Treatment Utilization Schedules, the use of opioids in the management of the patient's chronic pain be supported by a quantitative assessment of pain relief to support efficacy, documentation of functional benefit, manage side effects, and evidence of monitoring for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient is monitored for aberrant behavior, nor is there a quantitative assessment of pain relief related to medication usage. Therefore, the efficacy of this medication cannot be determined. Additionally, there is no documentation of functional benefit related to this medication. As such, the requested purchase of Ultram 50 mg #90 refill 1 is not medically necessary or appropriate.