

Case Number:	CM14-0010236		
Date Assigned:	02/21/2014	Date of Injury:	11/02/2003
Decision Date:	06/25/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/27/2014

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 Physical Medicine & Rehabilitation 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 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:

This 36 year-old patient sustained an injury on November 2, 2003 while employed by [REDACTED]. The diagnoses include low back pain; lumbosacral neuritis; lumbar intervertebral disc displacement; facet syndrome; and chronic pain syndrome. The report December 20, 2013 from the provider noted low back pain rated at 3/10. He had radiofrequency treatment to his back in April 2013 and has had increasing pain over the last couple of months and would like to repeat the procedure. Current medications list Norco, Pantoprazole, Topiramate, and Orphenadrine. Exam showed pain with maximal extension; palpable spasm or tightness in musculature over right facet joints; straight leg raise and prone knee bending resulted in increased right-sided low back pain. Treatment included medications refill and Radiofrequency ablation.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 LUMBAR RADIOFREQUENCY TREATMENT FOR THE RIGHT LOWER BACK: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES, 2ND EDITION (2004), CHAPTER 12 - LOW BACK COMPLAINTS, 300-301

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF

OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004),
CHAPTER 12 LOW BACK, 300-301

Decision rationale: Current medications list included Norco, Pantoprazole, Topiramate, and Orphenadrine. Exam showed pain with maximal extension; palpable spasm or tightness in musculature over right facet joints; straight leg raise and prone knee bending resulted in increased right-sided low back pain. Treatment included medications refill and Radiofrequency ablation. The patient underwent radiofrequency treatment on April 26, 2013. Report of March 2013 prior to procedure noted pain of 3/10 on VAS. In May 2013 subsequent to procedure noted pain scale of 4/10 and in June and August 2013 of 2/10. Per Guidelines, Facet joint radiofrequency neurotomy/ablation has conflicting evidence of efficacy and is considered under study without clear benefit or functional improvement. Criteria include documented failed conservative treatment trial without evidence of radicular findings not met here with continued radiating low back pain and positive SLR without clear facet arthropathy. Submitted reports have not demonstrated objective clinical findings of pain relief in terms of reduction in opioid prescription dosage and medical utilization or an increase in ADLs and function for greater than 50% sustained for at least 6 months duration for repeat procedures for this chronic injury. The request is not medically necessary.

1 PRESCRIPTION FOR NORCO 10/325 #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS, ONGOING MANAGEMENT,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS, 74-96

Decision rationale: Per the California MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities or decreased in medical utilization. There is no evidence of utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance as the patient had inconsistent drug screening negative for prescribed opiates in October 2013; however, no adjustment was made by the provider regarding the aberrant drug behavior. Review indicated recommendation for weaning in November 2013. The California MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain. The request is not medically necessary.

1 PRESCRIPTION FOR TRAMADOL CREAM 10%: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS - TRAMADOL (ULTRAM),

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, 111-113

Decision rationale: Per the California MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic over oral NSAIDs or other pain relievers for a patient with spinal and multiple joint pain without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic for this chronic injury of 2003 without documented functional improvement from treatment already rendered. The request is not medically necessary.