

Case Number:	CM14-0024806		
Date Assigned:	06/16/2014	Date of Injury:	06/11/1996
Decision Date:	09/26/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/27/2014

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 Family Medicine and is licensed to practice in Arizona. 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:

Patient is a 55 year old female with a date of injury on 6/11/1996. Diagnoses include disc protrusion, L4-5 microdiscectomy, thoracic pain, myofascial pain, depression, and neuropathic pain. Subjective complaints are of ongoing back pain and left leg pain. Pain level was rated at 5-6/10. Physical exam indicated tenderness in the neck, radicular pain in both legs, and decreased sensation in the lower extremities. Lumbar MRI from 9/11/13 showed a posterior disc bulge at L1-2, L3-4, and L5-S1. Medications include Soma, Oxycontin 40mg three times a day, oxycodone 15mg, lyrica, wellbutrin, and xanax. Request is for Abstral, Soma, medial branch blocks, basic metabolic panel (BMP), and liver function tests (LFTs). Patient had a BMP and LFTs certified in 8/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL L3-L4 MEDIAL BRANCH BLOCK: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) LOW BACK, FACET INJECTIONS.

Decision rationale: The California MTUS suggests that invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. The ODG states that facet joint medial branch blocks are only recommended as a diagnostic tool for consideration of the facet joint as a pain source. The ODG states that diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Treatment requires a diagnosis of facet joint pain. Criteria for facet joint pain are: Tenderness to palpation in the paravertebral areas; A normal sensory examination; Absence of radicular findings, although pain may radiate below the knee; and a normal straight leg raising exam. Injections should be limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally, and there is documentation of failure of conservative treatment prior to the procedure for at least 4-6 weeks. For this patient, criteria are not met for facet joint pain. There is evidence of radicular symptoms and decreased lower extremity sensation, and there is not documentation of recent conservative therapy. Therefore, the medical necessity for medial branch blocks is not established.

LIVER FUNCTION TEST: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Prim Care Companion CNS Disord. 2012; 14(3): PCC.11m01326. Published online Jun 14, 2012. doi: 10.4088/PCC.11m01326.

Decision rationale: The California MTUS is silent on routine laboratory testing for chronic pain patients; therefore other current guidelines were referenced. This patient has diagnoses that are consistent with chronic pain. Referenced guidelines indicate that chronic opioid therapy can adversely affect respiratory, gastrointestinal, musculoskeletal, cardiovascular, immune, endocrine, and central nervous systems. Due to this patient being on chronic opioid therapy, laboratory testing to evaluate hepatic and renal function are appropriate, and medically necessary.

BASIC METABOLIC PANEL: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Prim Care Companion CNS Disord. 2012; 14(3): PCC.11m01326. Published online Jun 14, 2012. doi: 10.4088/PCC.11m01326.

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adversely affect respiratory, gastrointestinal, musculoskeletal, cardiovascular, immune, endocrine, and central nervous systems. Due to this patient being on chronic opioid therapy, laboratory testing to evaluate hepatic and renal function are appropriate, and medically necessary.

SOMA 350MG #60: Upheld

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

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

Decision rationale: The California MTUS does not recommend Carisoprodol. This medication is not indicated for long-term use. This medication is only recommended for a 2-3 week period. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. This patient has used carisoprodol chronically, which is not consistent with current guidelines. For these reasons, the use of carisoprodol is not medically necessary.

TRIAL ABSTRAL 400UGM #32: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines FENTANYL Page(s): 47.

Decision rationale: The California MTUS states that Fentanyl is an opioid analgesic with potency eighty times that of morphine. Weaker opioids are less likely to produce adverse effects than stronger opioids such as Fentanyl. Submucosal forms of Fentanyl (Abstral) are not recommended for musculoskeletal pain. This form of Fentanyl is an opioid painkiller currently approved for the treatment of breakthrough pain in certain cancer patients. Therefore, the use of Abstral is not consistent with guideline recommendations, and the medical necessity is not established.