

Case Number:	CM15-0001480		
Date Assigned:	01/12/2015	Date of Injury:	05/16/2001
Decision Date:	03/12/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 65-year-old male who reported an injury on 05/16/2001. The mechanism of injury was not provided. On 01/12/2015, the injured worker presented for a followup and had complaints of pain located in the lower back. Prior therapy included medications and physical therapy. Current medications included Lyrica, Celebrex, Lexapro, Prilosec, and tramadol. The injured worker was noted to have signed a recent pain contract and was noted to have been receiving the lowest effective dose of pain medication. Diagnoses were lumbar spondylosis, primary localized osteoarthritis of the lower leg, congenital spondylosis of the lumbar spine, thoracic or lumbar neuritis or radiculitis, disorders of the sacrum, degenerative lumbar or lumbosacral intervertebral disc, and unspecified osteoporosis. Upon examination of the lumbar spine, there was decreased range of motion and negative straight leg raise. There was normal sensation and 5/5 strength. There was no tenderness to palpation over the bilateral lumbar paraspinals or thoracic paraspinals. The provider recommended tramadol 50 mg with a quantity of 120 and a bilateral L3, L4 and L5 neurolysis. The Request for Authorization form was dated 01/13/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg Qty 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram, Ultram ER, generic available in immediate releas.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The request for tramadol 50 mg Qty 120 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is no evidence of an objective assessment of the injured worker's pain level, functional status, and appropriate medication use. A current urine drug screen was not submitted for review. Additionally, there is no information on treatment history and length of time the patient has been prescribed tramadol. The provider's request does not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Bilateral L3, L4 and L5 Neurolysis: Upheld

Claims Administrator 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-Lumbar & Thoracic

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet joint radiofrequency neurotomy.

Decision rationale: The request for bilateral L3, L4 and L5 neurolysis is not medically necessary. The California MTUS/ACOEM Guidelines state that invasive techniques such as local injections or facet injections are of questionable merit. Facet neurotomies or neurolysis should be performed only after appropriate diagnostic blocks. The Official Disability Guidelines further state that a facet joint radiofrequency neurotomy is under study. There is conflicting evidence as to the efficacy of the procedure and approval for treatment should be made on a case by case basis only. Criteria for use of facet joint neurotomy include diagnosis of facet joint pain with the use of a medial branch block, no more than 2 joint levels to be performed at 1 time, evidence of a formal plan of additional evidence based conservative care in addition to facet joint therapy. There should be evidence that the patient had failed to respond to at least 4 weeks of conservative therapy to include physical therapy and medications. The documentation submitted for review lacked findings to support a diagnosis of facet pain. There is no evidence that the patient had a previous medial branch block. There is also a lack of evidence of the injured worker's failure to respond to conservative treatment for at least 4 weeks prior to the requested procedure. As such, medical necessity has not been established.