

<b>Case Number:</b>	CM15-0103763		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	10/03/2002
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 53 year old female, who sustained an industrial injury on 10/03/2002. The injured worker is currently permanently totally disabled. The injured worker is currently diagnosed as having status post pedestrian versus motor vehicle accident, status post left above the knee amputation, bilateral carpal tunnel syndrome, mechanical lumbar spine pain with herniated disc at L5-S1 with bilateral foraminal narrowing, chronic neurogenic pain to left lower extremity, degenerative joint disease to right knee, right saphenous nerve laceration of the mid- thigh, chronic edema to right lower extremity, scar disfigurement and contracture in the soft tissues of the right thigh, multiple medical psychiatric and pain issues, left distal femur chip fracture, bilateral ring finger trigger finger status post corticosteroid injection, right lateral epicondylitis status post corticosteroid injection, and right shoulder impingement status post injection. Treatment and diagnostics to date has included steroid injections with relief, use of prosthesis, and medications. In a progress note dated 04/02/2015, the injured worker presented with complaints of pain with tenderness and weakness to bilateral fingers and hands. Objective findings include tenderness at the right lateral epicondyle. The treating physician reported requesting authorization for Morphine extended release and radiofrequency neurolysis of the lumbar medial branches.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Morphine ED (extended release) 30 mg Qty 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89, 80.

**Decision rationale:** The patient presents with low back and right elbow pain. The request is for MORPHINE ED (EXTENDED RELEASE) 30 MG QTY 90. The request for authorization is not provided. The patient is status-post left above knee amputation, date unspecified. Physical examination of the bilateral elbows reveals focally tender at the right lateral epicondyle. The left elbow range of motion is nearly full and the elbow is stable. Her arms are hypertrophied from using crutches. Physical examination of the lumbar spine is not documented. Patient's diagnosis includes mechanical lumbar spine pain with herniated disc at L5-S1 with bilateral foraminal narrowing; chronic neurogenic pain, left lower extremity. Per progress report dated 04/02/15, the patient is permanent and stationary. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief." Pages 80,81 of MTUS also states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." Treater does not specifically discuss this medication. The patient has been prescribed Morphine since at least 08/12/13. MTUS requires appropriate discussion of the 4A's, however, in addressing the 4A's, treater does not discuss how Morphine significantly improves patient's activities of daily living with specific examples of ADL's. Analgesia is not discussed either, specifically showing significant pain reduction with use of Morphine. No validated instrument is used to show functional improvement. There are no documentation nor discussion regarding adverse effects and aberrant drug behavior. No USD, CURES or opioid contract. Furthermore, MTUS clearly does not support chronic opiate use for chronic low back pain. Therefore, the request IS NOT medically necessary.

**Radiofrequency Neurolysis of Medial Branches (lumbar) L4-L5 and L5-S1 (sacroiliac), Outpatient:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar & Thoracic chapter - Facet joint radiofrequency neurotomy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, under Facet joint radiofrequency neurotomy.

**Decision rationale:** The patient presents with low back and right elbow pain. The request is for RADIOFREQUENCY NEUROLYSIS OF MEDIAL BRANCHES (LUMBAR) L4-L5 AND L5-S1 (SACROILIAC), OUTPATIENT. The request for authorization is not provided. The patient is status-post left above knee amputation, date unspecified. Physical examination of the bilateral elbows reveals focally tender at the right lateral epicondyle. The left elbow range of motion is nearly full and the elbow is stable. Her arms are hypertrophied from using crutches. Physical examination of the lumbar spine is not documented. Patient's diagnosis includes mechanical lumbar spine pain with herniated disc at L5-S1 with bilateral foraminal narrowing; chronic neurogenic pain, left lower extremity. Per progress report dated 04/02/15, the patient is permanent and stationary. ODG, Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, under Facet joint radiofrequency neurotomy states: "Criteria for use of facet joint radiofrequency neurotomy: 1. Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections). 2. While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief, generally of at least 6 months duration. No more than 3 procedures should be performed in a year's period. 3. Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. 4. No more than two joint levels are to be performed at one time. 5. If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks. 6. There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy." Treater does not discuss the request. Per UR letter dated 05/19/15, reviewer states, "The patient has undergone radiofrequency thermal neurolysis with good relief." Given patient's positive response, a repeat Radiofrequency Neurolysis would appear to be indicated. However, ODG allows for repeat Radiofrequency Neurolysis when there is at least 12 weeks of 50% or more pain relief. In this case, treater has not documented how long the pain relief lasted following the previous Radiofrequency Neurolysis and whether or not pain reduction of 50% or more was achieved. Therefore, given the lack of documentation, the request IS NOT medically necessary.