

Case Number:	CM15-0081608		
Date Assigned:	05/04/2015	Date of Injury:	07/24/2009
Decision Date:	06/26/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	04/28/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 7/24/2009. Her diagnoses, and/or impressions, are noted to include: idiopathic scoliosis of the thoracolumbar spine; status-post thoracolumbar spine fusion; probable osteoarthritis; lower lumbar - upper thoracic facet syndrome; lumbosacral facet arthropathy (x-ray 10/29/13) with possible facet-generated pain; cervical sprain/strain; cephalgia secondary to cervical strain/sprain and scoliosis; lumbar radiculopathy and sacroiliac joint pain; and failed back syndrome. Her history notes pre-existing scoliosis and thoracolumbar fusion with Harrington rods in 1976; and revision surgery with removal of the rods, and with lumbar fusion with instrumentation, in 1982; a thoracic lumbar fusion in 2011; a posterior lumbar fusion with instrumentation in 1/2012 with no change in symptoms; and a cancerous skin lesion on the left para-spinal that might increase her risk for interventional spine modalities. Her treatments have included orthopedic panel qualified medical examination (1/10/10); posterior lumbar fusion surgeries; a caudal injection (2011) causing more pain; bilateral facet injection therapy effective; right sacroiliac injection therapy (3/6/14) unchanged symptoms; acupuncture treatments effective; physical therapy and home exercise program; transcutaneous electrical stimulation unit therapy ineffective; bilateral lumbosacral facet injections on 5/22/2014 with significant relief; and medication management. The progress notes of 12/8/2014 reported constant and worsening, moderate-severe spine pain that radiates into the lower back, buttock, hip and leg, with stiffness and warmth to the area. A lumbosacral fusion and bilateral lumbar medial branch radio-frequency ablation was recommended. The progress notes of 12/8/2014 reported unchanged, severe back pain, status-post injection

therapies. Stated was that her overall pain was stated as stable and unchanged from before, and that she was told she is not a candidate for a spinal cord stimulator because of the extensive scar tissue from scoliosis surgery in the thoracic-lumbar spine. Her examination findings noted signs & symptoms consistent with lumbar radiculopathy and sacroiliac joint pain, and that she did not wish to take any narcotic pain medication due to the side-effects. The physician's requests for treatments were noted to include Tramadol, Gabapentin, Mobic, Baclofen, a Toradol compound cream, and bilateral lumbar medial branch radio-frequency ablation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #90 with 3 refills (prescribed 2-25-15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Gabapentin 800mg #90 with 3 refills (prescribed 2-25-15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19.

Decision rationale: Neurontin (Gabapentin) is an anti-epilepsy drug which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The records document that the patient has reported radiculopathy related to his chronic low back condition, without evidence of neuropathic pain. There was no documentation of objective findings consistent with current

neuropathic pain to necessitate use of Neurontin. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

Mobic 15mg #90 with 3 refills (prescribed 2-25-15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nonsteroidal anti-inflammatory drug.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Mobic (Meloxicam), is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain in this condition. In this case, the patient has been on previous long-term NSAIDs without any documentation of significant improvement. Medical necessity of the requested medication, Mobic 15mg, has not been established. The request for this medication is not medically necessary.

Baclofen 20mg #30 with 3 refills (prescribed 2-25-15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California MTUS Guidelines and the ODG recommends non-sedating muscle relaxants, such as Baclofen, with caution as a second-line option for short-term treatment of acute low back pain (LBP), and for short-term (<2 weeks) treatment of acute exacerbations in patients with chronic LBP. The mechanism of action is blockade of the pre- and post-synaptic GABA receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. It is also a first-line option for the treatment of dystonia. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain. There is no documentation provided necessitating the use of Baclofen. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

Compound cream: Toradol 1gram with 3 refills (prescribed 2-25-15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic requested contains Toradol. Toradol is not recommended as a topical agent per CA MTUS guidelines. There is no peer-reviewed literature to support its use. It is evident from the records that the patient is able to use oral medications and there is no rationale provided for the use of topical cream. Medical necessity for the requested topical analgesic cream has not been established. The request for the topical analgesic is not medically necessary.

Bilateral L4, L5 medial branch radiofrequency ablation - One Time: 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 (ODG), Low Back - Lumbar & Thoracic, Facet joint radiofrequency neurotomy, Diagnostic blocks, Facet joint diagnostic blocks.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Medial Branch Blocks/ RFA.

Decision rationale: Medial branch blocks (MBBs) and radiofrequency ablations (RFA) are accepted pain management interventional techniques. However, specific criteria and standards of care apply for performing these procedures. According to the ODG, the criteria for the use of therapeutic MBBs are as follows: 1) no more than one therapeutic intra-articular block is recommended. 2) There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3) If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of 6 weeks) the recommendation is to proceed to a diagnostic medial branch block and subsequent neurotomy (if the MBB is positive). 4) No more than 2 joint levels may be blocked at any one time. In this case, the patient had a positive response to a therapeutic intraarticular facet joint injection on 5/22/14. However, there is no documentation that this patient has undergone a diagnostic MBB. Therefore, according to guideline criteria, an RFA is not supported. Medical necessity for the requested service has not been established. The requested procedure is not medically necessary.