

Case Number:	CM14-0147423		
Date Assigned:	09/15/2014	Date of Injury:	01/14/1997
Decision Date:	10/15/2014	UR Denial Date:	09/03/2014
Priority:	Standard	Application Received:	09/10/2014

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 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 is a 52-year-old male who reported an industrial injury on to the back and right lower extremity 1/14/1997 attributed to the performance of his usual and customary job tasks. An AME evaluation during 2002 diagnosed patient with status post 360 fusion of L4-L5 and L5-S1 with instrumentation; cervical spine HNP; and degenerative thoracic disc with small protrusions. The AME establish the patient as permanent stationary as of 5/22/2001. The patient reported ongoing back pain. The patient was documented to have a BMI of greater than 46 with a diagnosis of morbid obesity. There were no documented objective findings to the cervical spine. The patient was diagnosed with post laminectomy syndrome lumbar spine; lumbosacral spondylosis without myelopathy; and cervical spondylosis without myelopathy. The treatment plan included a bilateral C2-C3 medial branch blocks, MS Contin 15 mg #60 and bilateral radiofrequency ablation at L3.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 bilateral C2, 3 medical branch blocks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 174-75; 187;300;179 -180,Chronic Pain

Treatment Guidelines epidural steroid injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-facet joint diagnostic blocks; neck and upper back chapter-epidural steroid injections

Decision rationale: The request for the cervical MBB or facet blocks to bilateral C2 and C2 is inconsistent with the recommendations of the CA MTUS for the treatment of this injured worker. There is no objective evidence of facet arthropathy to the cervical spine as documented by a Cervical Spine MRI or x-ray imaging studies. There are no documented neurological deficits. There is no documented pain on extension/rotation of the cervical spine. The treatment of the patient with facet blocks is recommended by based on the assessment of facet-mediated pain; however, there was no documented pain with rotation and extension of the cervical spine. The patient is assessed as having a facet pain generator. There are no objective findings on examination to support the contention of facet generated pain. The use of facet blocks and RFA to the cervical spine is not recommended by the CA MTUS. The ACOEM Guidelines state that facet blocks are of "questionable merit." The CA MTUS states that facet blocks are "limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally." The patient is diagnosed with neck and shoulder/back pain and the evaluation of this pain generator should occur prior to the evaluation and treatment of assessed facet pain. The treating physician provided insufficient subjective and objective evidence to support the medical necessity of diagnostic cervical facet block in the anticipation of performing RFA or for the treatment of chronic neck pain. The provider did not support his request with the criteria recommended by the evidence-based guidelines. The request for the authorization of diagnostic facet blocks or median branch blocks for chronic cervical spine pain is inconsistent with the recommendations of the CA MTUS, the ACOEM Guidelines, and the Official Disability Guidelines (ODG). The recommendations are for the provision of facet blocks is not recommended. There is no provided objective evidence that the axial cervical pain or degenerative disc disease is influenced by additional pain generated from facet arthropathy. There is no demonstrated medical necessity for the requested medial branch block at bilateral C2 and C3. Therefore, this request is not medically necessary.

1 prescription of MS Contin 15mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2ndEdition, (2004) chapter 6 pages 114-116; Official Disability Guidelines (ODG) pain chapter opioids

Decision rationale: Evidence-based guidelines recommend short-term use of opioids for the management of chronic nonmalignant moderate to severe pain. Long-term use is not recommended for nonmalignant pain due to addiction, dependency, intolerance, abuse, misuse and/or side effects. Ongoing opioid management criteria are required for long-term use with evidence of reduce pain and improve function as compared to baseline measurements or a return to work. The prescription for MS Contin 15 mg #60 for short acting pain relief is being

prescribed as an opioid analgesic for the treatment of chronic pain to the back and neck for the date of injury. The objective findings on examination do not support the medical necessity for continued opioid analgesics for the diagnosis of mechanical neck and back pain. The patient is being prescribed opioids for mechanical back/neck pain post operatively, which is inconsistent with the recommendations of the CA MTUS. There is no objective evidence provided to support the continued prescription of opioid analgesics for the cited diagnoses. There is no demonstrated medical necessity for the continuation of opioids for the effects of the industrial injury. The chronic use of MS Contin 15 mg #60 is not recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic back or neck pain. The prescription of opiates on a continued long-term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of non-steroidal anti-inflammatory drugs (NSAIDs) for the treatment of chronic pain. The current prescription of opioid analgesics is inconsistent with evidence-based guidelines. The prescription of opiates on a continued long-term basis is inconsistent with the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain issues. The ACOEM Guidelines updated chapter on chronic pain states, "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect." ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also notes, "Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function." There is no clinical documentation by with objective findings on examination to support the medical necessity of MS Contin 15 mg for this long period of time or to support ongoing functional improvement. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with the prescribed MS Contin 15 mg. There is no demonstrated medical necessity for the prescribed opioids. Therefore, this request is not medically necessary.