

Case Number:	CM15-0114984		
Date Assigned:	06/23/2015	Date of Injury:	10/27/1975
Decision Date:	07/29/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/15/2015

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:

This 62 year old male sustained an industrial injury to the back and neck on 10/27/75. Documentation indicated that previous treatment included lumbar discectomy and laminectomy surgeries, spinal cord stimulator and medications. The injured worker underwent radiofrequency neurotomy of medial branch nerves for left C4-5 and C5-6 on 4/17/15 with 75% reduction in severe neck pain associated with less frequent headaches and improved neck mobility. In a pain medicine reevaluation dated 4/27/15, the injured worker reported that he was moving from his home. With repetitive bending, lifting and boxing, the injured worker reported having more severe low back and extremity pain. The physician noted that computed tomography showed multilevel disc disease. Physical exam was remarkable for significant tenderness to palpation in the low back as well as some tenderness to palpation in the upper back and neck region with limited and painful range of motion. The injured worker could not stand up straight. The injured worker had superficial skin hypersensitivity over the areas where the facet nerves had been treated with radiofrequency neurotomy. In a request for authorization dated 5/27/15, the injured worker complained of persistent upper lumbar and lower thoracic pain that was not within the range of the spinal cord stimulator. The physician that due to disc pathology and compression fractures resulting in muscle spasms, the pain could be severe enough to cause nausea and vomiting. Current diagnoses included lumbar post laminectomy syndrome, lumbar or thoracic radiculitis and disorder of elbow. The treatment plan included requesting authorization for diagnostic injections at right L4-5 and L5-S1 facets to address right low back pain, a medically supervised weight loss program, pending electromyography of bilateral lower extremities and medication refills (Norco, Robaxin, Omeprazole, Opana ER and Gabapentin).

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right L3, L4, & L5 medial branch blocks: 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.

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

Decision rationale: Medial branch blocks (MBBs) 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: No more than one therapeutic intra-articular block is recommended; there should be no evidence of radicular pain, spinal stenosis, or previous fusion, and 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 (with subsequent neurotomy if the MMB is positive). In addition, no more than 2 joint levels may be blocked at any one time, and there should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy. In this case, there is no documentation of facet medicated pain in the lumbar spine or a recent course of physical therapy for the chronic low back pain. In addition, this patient has had prior radiofrequency ablation (RFA) at the same spinal levels as the requested MBBs, which resulted in a poor outcome. This patient subsequently required an increase in pain medication within 3 months after the RFA. Medical necessity for the requested service has not been established. Therefore, the requested service is not medically necessary.

Norco 180 tablets 10/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to MTUS and ODG, Norco 5/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

30 Tablets of Opana ER 20mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids.

Decision rationale: Opana ER (Hydromorphone/Dilaudid) is a semi-synthetic opioid analgesic which affects the central nervous system and is indicated for the treatment of moderate to severe pain. According to California 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 opiate, and the duration of pain relief. There is insufficient evidence in the clinical literature that long term use of narcotic medications results in any functional improvement. In this case, the documentation provided for review did not identify any particular functional improvement obtained with the ongoing use of Opana ER. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

30 Tablets of Gabapentin 300mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 17-19, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gabapentin (Neurontin).

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.

1 [REDACTED] weight loss program: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate.

Decision rationale: There is no specific documentation addressed by ACOEM/MTUS Guidelines for weight loss programs for chronic pain conditions. According to UpToDate, weight loss is beneficial for partial relief of symptoms for patients with obesity and arthritis. All patients who would benefit from weight loss should receive counseling on diet, exercise and goals for weight management. The evidence-based recommendations indicate that medical

management of obesity can be accomplished by the primary care physician via diet, exercise, and optional medications. There is no documentation that any attempts at weight loss have been employed. The provider has not indicated a specific goal for weight loss and there is no documentation indicating that the patient has undergone any counseling on lifestyle and behavioral modifications. In addition, there is no specific documentation indicating that the claimant's obesity is related to her work injury. There is no scientific evidence to support the use of the [REDACTED] weight loss program over medical management of weight loss. Medical necessity for the requested program has not been established. The requested service is not medically necessary.