

Case Number:	CM14-0112956		
Date Assigned:	08/01/2014	Date of Injury:	01/06/2001
Decision Date:	10/15/2014	UR Denial Date:	07/10/2014
Priority:	Standard	Application Received:	07/18/2014

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 Psychiatry 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:

Injured worker is a 40 year old male with date of injury 1/6/2001. Date of the UR decision was 7/10/2014. Injured worker suffered from bilateral knee pain. Report dated 8/30/2012 suggested that injured worker was having knee pain and increased pain level and was being prescribed Soma, Dilaudid, Norco and Oxycontin. It was indicated she had been on these medications for 6 months prior to that visit. Report dated 7/10/2014 indicated that he presented with bilateral knee pain which was unchanged from the prior visit. His quality of sleep was poor; quality of life was described as unchanged. It was suggested that the medications were working well for him and medication abuse was not suspected. He was being prescribed Ultram 50 mg four times daily as needed, Soma 350 mg four times daily as needed, Methadone 30 mg three times daily, Lyrica 50-100 mg daily, Dilaudid 8 mg four times daily as needed. It was suggested that the injured worker had poor tolerance with Lyrica and hence had stopped taking it. It was suggested that the injured worker has completed at least 8 individual psychotherapy treatment sessions with limited improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 referral to psychologist for 12 additional sessions of psychotherapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; psychological evaluatio.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 23, 100-102.

Decision rationale: California MTUS states that behavioral interventions are recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. The ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain, recommends screening for patients with risk factors for delayed recovery, including fear avoidance beliefs. Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone: -Initial trial of 3-4 psychotherapy visits over 2 weeks, -With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions). Upon review of the submitted documentation, it is gathered that the injured worker has had at least 8 psychotherapy sessions with limited improvement. Injured worker had not had any signs of objective functional improvement from it. The guidelines recommend total of 10 sessions with evidence of functional improvement. The request for 1 referral to psychologist for 12 additional sessions of psychotherapy exceeds the guideline recommendations as the injured worker has already completed at least 8 sessions with limited improvement. Therefore the request is not medically necessary.

1 prescription of Lyrica 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines (May 2009); Lyrica (preg.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica)>, Page(s): 17, 19, 99.

Decision rationale: MTUS guidelines stated that Pregabalin (Lyrica) has been documented to be effective in treatment of diabetic neuropathy and post herpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia. Injured worker suffered from bilateral knee pain. Report dated 7/10/2014 suggests that he had poor tolerance with Lyrica and hence had stopped taking it. Continuation of Lyrica is not medically indicated based on injured worker's poor tolerance to it which resulted in him discontinuing the medication. Thus, the request for 1 prescription of Lyrica 50mg #60 is not medically necessary.

1 prescription of Methadone 10mg #252: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines (May 2009); Methadone.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Page(s): 62.

Decision rationale: MTUS guidelines state that Methadone is recommended as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk. The FDA reports that they have received reports of severe morbidity and mortality with this medication. This appears, in part, secondary to the long half-life of the drug (8-59 hours). Pain relief on the other hand only lasts from 4-8 hours. Methadone should only be prescribed by providers experienced in using it. Pharmacokinetics: Genetic differences appear to influence how an individual will respond to this medication. Following oral administration, significantly different blood concentrations may be obtained. Vigilance is suggested in treatment initiation, conversion from another opioid to methadone, and when titrating the methadone dose. Adverse effects: Delayed adverse effects may occur due to methadone accumulation during chronic administration. Systemic toxicity is more likely to occur in patients previously exposed to high doses of opioids. This may be related to tolerance that develops related to the N-methyl-D-aspartate (NMDA) receptor antagonist. Patients may respond to lower doses of methadone than would be expected based on this antagonism. One severe side effect is respiratory depression (which persists longer than the analgesic effect). Methadone should be given with caution to patients with decreased respiratory reserve (asthma, COPD, sleep apnea, severe obesity). QT prolongation with resultant serious arrhythmia has also been noted. Use methadone carefully in patients with cardiac hypertrophy and in patients at risk for hypokalemia (including those patients on diuretics). Methadone does have the potential for abuse. Precautions are necessary as well for employees in safety sensitive positions, including operation of a motor vehicle. Steps for prescribing methadone: (1) Basic rules. Weigh the risks and benefits before prescribing methadone. Avoid prescribing 40 mg Methadone tablets for chronic non-malignant pain. This product is only FDA-approved for detoxification and maintenance of narcotic addiction. Closely monitor patients who receive methadone, especially during treatment initiation and dose adjustments. (2) Know the information that is vital to give the patient; don't be tempted to take more methadone than prescribed if you are not getting pain relief. This can lead to a dangerous build-up that can cause death, all changes in methadone dose should be made by your treating practitioner, methadone can make your breath slow down, or actually stop, methadone can slow down your heartbeat and you might not be able to detect this, if you feel like you are having an irregular heartbeat, dizziness, light-headedness or fainting, call your doctor or clinic immediately. (3) Be familiar with the current SAMHSA health advisory on methadone. The medication has become more accessible to unauthorized users. It can accumulate in potentially harmful doses (especially during the first few days of treatment. There has been a rise in Methadone-associated mortality. (4) Be familiar with the FDA final policy statement on Methadone that explicitly discusses the topic, "Can Methadone be used for pain control?" No separate registration is required to prescribe methadone for treatment of pain. (5) Read the new prescribing information for Methadone and the new patient information section. (6) Multiple potential drug-drug interactions can occur with the use of Methadone. A complete list of medications should be obtained prior to prescribing methadone to avoid adverse events, and the patient should be warned to inform any other treating physician that they are taking this medication prior to starting and/or discontinuing medications. Upon review of the submitted documentation, it has been suggested that injured worker has been on multiple opiate medications since 2012. He was on Soma, Dilaudid, Norco and Oxycontin since 2012 and most currently has been prescribed Ultram 50 mg four times daily as needed, Soma 350 mg four times daily as needed, Methadone 30 mg three times daily, Lyrica 50-100 mg daily, Dilaudid 8 mg four times daily as needed. The request for 1 prescription of Methadone 10mg #252 is excessive and not medically necessary based on the fact that the injured worker has been continued to be prescribed multiple opiate medications at high doses for years and still continues to present with bilateral knee pain which was unchanged from the prior visits per the report dated 7/10/2014 Therefore the request is not medically necessary.