

Case Number:	CM15-0143361		
Date Assigned:	08/04/2015	Date of Injury:	06/10/2003
Decision Date:	09/22/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/24/2015

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:

This is a 54-year-old male with a June 10, 2003 date of injury. A progress note dated June 17, 2015 documents subjective complaints (chronic cervicolumbar pain with bilateral radicular pain; cervicogenic headache; chronic bilateral knee pain), objective findings (neuro grossly intact), and current diagnoses (chronic cervicolumbar pain with bilateral radicular pain; cervicogenic headache; chronic bilateral knee pain). Treatments to date have included medications, imaging studies, and physical therapy. The medical record indicates that medications help control the pain and improve functioning. The treating physician documented a plan of care that included Methadone 10mg #540, Oxy IR 30mg #150, Valium 10mg #90, two lead transcutaneous electrical nerve stimulator unit (indefinite use), and a back brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 10mg #540: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88,89.

Decision rationale: The patient presents with chronic cervicolumbar pain with bilateral radicular pain, cervicogenic headache, and chronic bilateral knee pain rated 5/10 with and 10/10 without meds. The request is for METHADONE 10MG #540. The request for authorization is not dated. MRI of the lumbar spine, 02/11/15, shows no change in appearance of the mild degenerative disc disease of the lower lumbar spine with a small central annular tear at L5-S1; no visible nerve root impingement. Patient is meeting treatment goals with decrease pain, increase function without side effects. Patient's functioning and ADL's improved include improved mood, improved sleep, walking, less time in bed, cooking, cleaning, more interactive with family, shopping, church and exercising. Patient's medications include Methadone, Oxy IR, Valium, Celebrex and Lidoderm Patch. The patient's work status is not provided. 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. MTUS p77 states, "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Treater does not specifically discuss this medication. The patient has been prescribed Methadone since at least 01/28/15. MTUS requires appropriate discussion of the 4A's, and in addressing the 4A's, treater does discuss how Methadone significantly improves patient's activities of daily living with specific examples of ADL's. Analgesia is discussed also, specifically showing significant pain reduction with use of Methadone. There is documentation regarding adverse effects and aberrant drug behavior. However, MTUS does not support greater than 120 mg equivalent Morphine dosing without pain management specialty consult and very special circumstances. This request is for 2160 mg equivalent Morphine dosing, which appears excessive. Finally, while the treater discusses some specific ADL's, it is not known that the patient would be unable to self-care based on the condition provided. Therefore, the request IS NOT medically necessary.

Oxy IR 30mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88,89.

Decision rationale: The patient presents with chronic cervicolumbar pain with bilateral radicular pain, cervicogenic headache, and chronic bilateral knee pain rated 5/10 with and 10/10 without meds. The request is for OXY IR 30MG #150. The request for authorization is not dated. MRI of the lumbar spine, 02/11/15, shows no change in appearance of the mild degenerative disc disease of the lower lumbar spine with a small central annular tear at L5-S1; no visible nerve root impingement. Patient is meeting treatment goals with decrease pain, increase function without side effects. Patient's functioning and ADL's improved include improved mood, improved sleep, walking, less time in bed, cooking, cleaning, more interactive with family, shopping, church and exercising. Patient's medications include Methadone, Oxy IR, Valium, Celebrex and Lidoderm Patch. The patient's work status is not provided. 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. MTUS p77 states, "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Treater does not specifically discuss this medication. The patient has been prescribed Oxy IR since at least 01/28/15. MTUS requires appropriate discussion of the 4A's, and in addressing the 4A's, treater does discuss how Oxy IR significantly improves patient's activities of daily living with specific examples of ADL's. Analgesia is discussed also, specifically showing significant pain reduction with use of Oxy IR. There is documentation regarding adverse effects and aberrant drug behavior. However, MTUS does not support greater than 120 mg equivalent Morphine dosing without pain management specialty consult and very special circumstances. This request is for 225 mg equivalent Morphine dosing, which appears excessive. Finally, while the treater discusses some specific ADL's, it is not known that the patient would be unable to self-care based on the condition provided. Therefore, the request IS NOT medically necessary.

Valium 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 24.

Decision rationale: The patient presents with chronic cervicolumbar pain with bilateral radicular pain, cervicogenic headache, and chronic bilateral knee pain rated 5/10 with and 10/10 without meds. The request is for VALIUM 10MG #90. The request for authorization is not dated. MRI of the lumbar spine, 02/11/15, shows no change in appearance of the mild degenerative disc disease of the lower lumbar spine with a small central annular tear at L5-S1; no visible nerve root impingement. Patient is meeting treatment goals with decrease pain, increase function without side effects. Patient's functioning and ADL's improved include improved mood, improved sleep, walking, less time in bed, cooking, cleaning, more interactive with family, shopping, church and exercising. Patient's medications include Methadone, Oxy IR, Valium, Celebrex and Lidoderm Patch. The patient's work status is not provided. MTUS guidelines state on page 24 that benzodiazepines are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks." Treater does not specifically discuss this medication. The patient has been prescribed Valium since at least 01/28/15. However, MTUS guidelines does not recommend its use for long-term and limits use to 4 weeks. The request for additional Valium #90 exceeds guideline recommendation, and does not indicate intended short-term use of this medication. Therefore, the request IS NOT medically necessary.

TENS unit 2 lead (indefinite use): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of TENS Page(s): 116.

Decision rationale: The patient presents with chronic cervicolumbar pain with bilateral radicular pain, cervicogenic headache, and chronic bilateral knee pain rated 5/10 with and 10/10 without meds. The request is for TENS UNIT 2 LEAD (INDEFINITE USE). The request for authorization is not dated. MRI of the lumbar spine, 02/11/15, shows no change in appearance of the mild degenerative disc disease of the lower lumbar spine with a small central annular tear at L5-S1; no visible nerve root impingement. Patient is meeting treatment goals with decrease pain, increase function without side effects. Patient's functioning and ADL's improved include improved mood, improved sleep, walking, less time in bed, cooking, cleaning, more interactive with family, shopping, church and exercising. Patient's medications include Methadone, Oxy IR, Valium, Celebrex and Lidoderm Patch. The patient's work status is not provided. MTUS Chronic Pain Management Guidelines the criteria for use of TENS in chronic intractable pain (p116) "a one month trial period of the TENS unit should be documented (as an adjunct to other treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function during this trial." Treater does not discuss the request. Treater does not specify if this request is for a rental or a purchase. MTUS requires documentation of one month prior to dispensing home units. Guidelines also require documentation of use of TENS, as an adjunct to other treatment modalities, within a functional restoration approach. In this case, there is no record that patient has trialed a TENS unit in the past, and a trial would be indicated. Therefore, the request IS NOT medically necessary.

Back brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic), lumbar supports.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic Chapter, under lumbar supports.

Decision rationale: The patient presents with chronic cervicolumbar pain with bilateral radicular pain, cervicogenic headache, and chronic bilateral knee pain rated 5/10 with and 10/10 without meds. The request is for BACK BRACE. The request for authorization is not dated. MRI of the lumbar spine, 02/11/15, shows no change in appearance of the mild degenerative disc disease of the lower lumbar spine with a small central annular tear at L5-S1; no visible nerve root impingement. Patient is meeting treatment goals with decrease pain, increase function without side effects. Patient's functioning and ADL's improved include improved mood, improved sleep, walking, less time in bed, cooking, cleaning, more interactive with family, shopping, church and exercising. Patient's medications include Methadone, Oxy IR, Valium, Celebrex and Lidoderm Patch. The patient's work status is not provided. ACOEM Guidelines page 301 on lumbar bracing states, "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ACOEM guidelines further state that they are not recommended for treatment, but possibly used for prevention if the patient is

working. ODG Low Back: Lumbar & Thoracic Chapter, lumbar supports topic, states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." For post-operative bracing, ODG states, "Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician." Treater does not discuss the request. However, guidelines recommend lumbar bracing only for the acute phase of symptom relief, compression fractures, treatment of spondylolisthesis and documented instability. No evidence of aforementioned conditions is provided for this patient. There is no evidence of recent back surgery, either. For non-specific low back pain, there is very low quality evidence, and ACOEM guidelines do not support the use of a back brace for chronic pain. Therefore, the request IS NOT medically necessary.