

Case Number:	CM15-0205596		
Date Assigned:	10/22/2015	Date of Injury:	06/27/2007
Decision Date:	12/04/2015	UR Denial Date:	10/16/2015
Priority:	Standard	Application Received:	10/20/2015

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, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 47 year old male injured worker suffered an industrial injury on 6-27-2007. The diagnoses included chronic pain syndrome, pain in the joint of the forearm, knee strain-sprain, enthesopathy of the knee and lumbar disc displacement without myelopathy. The note of 7-17-2015 indicated the injured worker had been taking 5 Norco and 6 Methadone when he started in that practice and had been taking these medications for 5 years. As of that date he was no longer taking Norco and was taking Methadone 10mg, 5 tablets a day which enabled him to return to work part time. On 10-6-2015 the treating provider reported lumbar spine and bilateral knee pain with no relief from physical therapy 36 sessions, 5 to 6 nerve blocks for the back, 4 cortisone injections to each knee, acupuncture 12 sessions and moderate relief from TENS unit and heat treatment. The low back pain radiated to the bilateral lower extremities and was awaiting approval for lumbar epidural steroid injection. He reported the pain was rated 6 to 7 out of 10 with medication. On exam the lumbar spine had restricted range of motion with tenderness and tight muscle bands. The straight leg raise and Faber test were positive. He continued to require 5 tablets of Methadone for pain relief despite failed trails of medication reduction due to increased pain. Prior treatments include lumbar epidural steroid injection 10-2014 with pain relief lasting about 4 months. The documentation provided did include evidence of pain levels with medication but no levels included without medication, evidence of functional improvement with treatment as evidenced by returning to work part time and no comprehensive aberrant risk assessment. The medical record did indicate a opioid contract was in place but no CURES report or urine drug screens. The Utilization Review on 10-16-2015 determined modification for

Methadone 10mg #60 to #35 and non-certification for Bilateral L5-S1 Transforaminal lumbar epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Methadone 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Methadone.

Decision rationale: Per CA MTUS, Medications for chronic pain page 60, methadone is a listed medication for the use in treating chronic pain. The guidelines state Recommended as indicated below. Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. Additionally per CA MTUS, Methadone, page 61: 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. (Clinical Pharmacology, 2008) Based upon the records reviewed there is insufficient evidence to support chronic use of methadone. There is lack of demonstration of urine toxicology compliance or increase in activity from the exam note of 10/16/15. There is inadequate documentation of a failure of a first line medication. Therefore the determination is for non-certification NOT medically necessary.

1 Bilateral L5-S1 Transforaminal lumbar epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, Epidural injections, page 46, Recommended as an option for treatment of radicular pain

(defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Specifically the guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. In addition there must be demonstration of unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). CA MTUS criteria for epidural steroid injections are: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case the exam notes from 10/6/15 do not demonstrate a failure of conservative management or a clear evidence of a dermatomal distribution of radiculopathy. Therefore the determination is for non-certification, not medically necessary.