MAXIMUS Federal Services

Case Number:	CM15-0224708		
Date Assigned:	11/23/2015	Date of Injury:	12/21/1998
Decision Date:	12/31/2015	UR Denial Date:	11/06/2015
Priority:	Standard	Application Received:	11/16/2015

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: Montana, Oregon, Idaho
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 injured worker is a 56 year old, female who sustained a work related injury on 12-21-98. A review of the medical records shows she is being treated for neck and low back pain. In the progress notes dated 9-28-15 and 10-27-15, the injured worker reports moderate, persistent low back pain. She describes the pain as deep, discomforting and stabbing. She rates her pain a 4 out of 10 with medications and a 9 out of 10 without medications. She states she has pain in legs with walking. She has a headache. Upon physical exam dated 10-27-15, she has tenderness over lumbar paraspinal facets. She has mild spasm. She has painful and decreased lumbar range of motion. Treatments have included medications, lumbar epidural steroid injection, and trigger point injections in neck. Current medications include Multi-Day tab, Levothyroxine, Calcium, Lipitor, Clobetasol ointment, Estrace cream, Aspirin, Neurontin, Arthrotec, Norco and Methadone. She has been taking the Methadone and Arthrotec since at least February, 2015. She is working full time. The treatment plan includes requests for refills of medications and for a lumbar pillow. The Request for Authorization dated 10-27-15 has requests for Norco, Neurontin, Methadone, Arthrotec and for a lumbar pillow. In the Utilization Review dated 11-6-15, the requested treatments of Methadone HCL 10mg. #30, Arthrotec 75mg.-200mg. #360 and a lumbar pillow are not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone HCL 10 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

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

Decision rationale: Recommended as indicated below. Opioids: For opioids a slow taper is recommended. The longer the patient has taken opioids, the more difficult they are to taper. The process is more complicated with medical comorbidity, older age, female gender, and the use of multiple agents. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. (Benzon, 2005) Patients with complex conditions with multiple comorbidities (including psych disorders) should be referred to an addiction medicine/psychiatry specialist. Opioid weaning should include the following: (a) Start with a complete evaluation of treatment, comorbidity, psychological condition. (b) Clear written instructions should be given to the patient and family. (c) If the patient cannot tolerate the taper, refer to an expert (pain specialist, substance abuse specialist). (d) Taper by 20 to 50% per week of original dose for patients who are not addicted (the patient needs 20% of the previous day's dose to prevent withdrawal). (e) A slower suggested taper is 10% every 2 to 4 weeks, slowing to a reductions of 5% once a dose of 1/3 of the initial dose is reached. (f) Greater success may occur when the patient is switched to longer-acting opioids and then tapered. (g) Office visits should occur on a weekly basis. (h) Assess for withdrawal using a scale such as the Subjective Opioid Withdrawal Scale (SOWS) and Objective Opioid Withdrawal Scale (OOWS) & (i) Recognize that this may take months. In this case, the worker is 56 years old and was injured in 1998. She has been treated for chronic neck and low back pain with long-term opioids. The documentation supports that methadone is being used to assist with shorter acting opioid weaning. However, the clinical notes over a four month period document increased methadone dosages without a corresponding decrease short acting opioid. In addition weekly office visits as recommended in the guidelines are not supported in the documentation. The documentation does not support methadone being used in a weaning program supported by the guidelines. Therefore, the request is not medically necessary.

Arthrotec 75 mg-200 mcg #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, specific drug list & adverse effects. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain.

Decision rationale: Arthrotec is a combination medication consisting of Diclofenac and misoprostol. The CA MTUS is non-specific on the recommendations for

prescribing of Diclofenac. According to the ODG-TWC, pain section, Diclofenac is not recommended as first line due to increased risk profile. A large systematic review of available evidence on NSAIDs confirms that Diclofenac, a widely used NSAID, poses an equivalent risk of cardiovascular events to patients as did rofecoxib (Vioxx), which was taken off the market. According to the authors, this is a significant issue and doctors should avoid Diclofenac because it increases the risk by about 40%. In this case there is no documentation of failure of a first line NSAID and the guidelines specifically recommend against use of the requested medication. Therefore, the request is not medically necessary.

Lumbar pillow: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee and leg, low back.

Decision rationale: CA MTUS/ACOEM guidelines are silent on the issue of DME. Per the ODG Knee and Leg section, Durable medical equipment, is generally defined as a device that meets Medicare definition. The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. Lumbar supports are not recommended for prevention. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective, and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. In this case, lumbar supports re not recommended by the guidelines and therefore the request is not medically necessary.