

Case Number:	CM15-0121275		
Date Assigned:	07/02/2015	Date of Injury:	06/27/2007
Decision Date:	07/31/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	06/23/2015

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:

The injured worker is a 47 year old male who sustained an industrial injury on 6/27/07. He had complaints of low back pain. Progress note dated 6/12/15 reports continued low back and bilateral knee pain. The back pain is burning and tingling and radiates down his bilateral extremities up to his knees. The pain increases with less medication and is aggravated by prolonged walking, sitting and laying down. He has trouble going up and down stairs and uses a cane for balance. Pain level is reported as 3/10 with pain medication. He is working part time and notes that the methadone is helping improve his pain level and function. Past epidural injections have provided some short-term relief. Diagnoses include: chronic pain syndrome, pain in joint of forearm, sprains and strains of knee and leg not otherwise specified, enthesopathy of knee, and lumbar disc displacement without myelopathy. Current regimen is not working well to control his ongoing back pain and bilateral knee pain. Plan of care includes increase methadone 10 mg NTE 5 tabs per day #150, discontinue Norco, continue ambien, get baseline EKG since he is on methadone, epidural steroid injections repeated as needed and encourage home exercises. Follow up in 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve (12) lead electrocardiogram (EKG): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Page(s): 61-62. Decision based on Non-MTUS Citation ODG, Pain, Methadone, Cardiac safety and EKG monitoring, pages 763-766.

Decision rationale: Request for EKG was to evaluate for any possible QT interval prolongation while on Methadone. The request(s) for EKG (electrocardiogram) was non-certified on 8/25/14. Per MTUS regarding Methadone use, there is high potential for abuse, QT prolongation with resultant serious arrhythmia has also been observed, and care should be taken in patients with cardiac hypertrophy and in those at risk for hypokalemia including those patients on diuretics; however, is silent on EKG monitoring. ODG states Methadone use has been associated with increased risk for QT prolongation and torsade de pointes (Tdp), especially in patients on high daily doses >100 mg/day with underlying cardiac disease such as history of arrhythmia, syncope, structural heart disease, or seizures of syncope that may develop after initiation of treatment, not demonstrated here. EKG is recommended during pretreatment, with repeat in 30 days from initiation, and annually for patients with demonstrated cardiac disease not identified in submitted reports. Submitted reports indicate the patient continues on dose of Methadone 10 mg with maximum daily dose of 5 tablets (50 mg). There is no report of underlying cardiac disease to pose increase risk to support frequent EKG monitoring outside guidelines criteria. The Twelve (12) lead electrocardiogram (EKG) is not medically necessary and appropriate.

Methadone 10mg, #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone; Opioids, long-term assessment; Weaning of Medications Page(s): 61-62, 88, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Review indicates the patient has been taking Methadone and Norco since at least 2012 with previous recommendations to taper since at least October 2014 of last year. The patient continues on high MED doses without attempt to wean. Current request was modified to assist in tapering off Methadone for this chronic injury of 2007 without functional benefit from continued use. Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in work status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and

compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain. Guidelines do not support chronic use of opioids and pain medications are typically not useful in the sub acute and chronic phases, impeding recovery of function in patients. Methadone, a synthetic opioid, may be used medically as an analgesic, in the maintenance anti-addictive for use in patients with opioid dependency and in the detoxification process (such as heroin or other morphine-like drugs) as a substitute for seriously addicted patients because of its long half-life and less profound sedation and euphoria. Recommendations for weaning include reduction of 10% every 2-4 weeks down to 5% once a dose of one third of initial dosing has been reached. Submitted reports have not adequately identified significant clinical findings or red- flag conditions to continue the opiate for this unchanged chronic injury without functional benefit. The Methadone 10mg, #150 is not medically necessary and appropriate.

One (1) epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injections Page(s): 46.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. Submitted reports have not demonstrated any correlating neurological deficits or remarkable diagnostics to support the epidural injections. In addition, to repeat a LESI in the therapeutic phase, repeat blocks should be based on continued objective documented decreasing pain and increasing functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. The patient underwent previous LESI in October 2014 without noted benefit. Criteria for repeating the epidurals have not been met or established as the patient continues to treat for chronic pain without functional benefit from previous injections in terms of decreased pharmacological formulation, increased ADLs and decreased medical utilization. There is also no documented failed conservative trial of physical therapy, medications, activity modification, or other treatment modalities to support for the epidural injection. Lumbar epidural injections may be an option for delaying surgical intervention; however, there is no surgery planned or identified pathological lesion noted. The One (1) epidural steroid injection is not medically necessary and appropriate.