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| Case Number: | CM15-0177118 | | |
| Date Assigned: | 09/17/2015 | Date of Injury: | 04/28/2010 |
| Decision Date: | 11/09/2015 | UR Denial Date: | 08/20/2015 |
| Priority: | Standard | Application Received: | 09/09/2015 |

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 69 year old female who sustained an industrial injury on 4-28-10. A review of the medical records indicates she is undergoing treatment for chronic low back pain, lumbar strain, lumbar degenerative disc disease, and lumbar radiculopathy with bilateral lower extremity pain, MPS, obesity, allergic rhinitis, and right forearm pain - status post reconstruction surgery. Medical records (7-15-15 to 8-6-15) indicate ongoing complaints of bilateral shoulder, neck, lumbar and bilateral knee pain. She reports that the shoulder pain radiates to the arms. She reports her wrist pain is associated with 'cracking, popping, and burning'. The physical exam (7-15-15) indicates no limitation of range of motion of the cervical spine. Slight motor deficit was noted of the deltoid muscle bilaterally, 4 out of 5. The sensory exam was within normal limits for the upper extremities. No tenderness, range of motion deficit, or impingement signs were noted of the bilateral shoulders. Range of motion was within normal limits of the elbows, wrists, and hands bilaterally. Flexion and extension of the lumbar spine was noted at 60%, lateral bending at 90%. Straight leg raising was negative bilaterally. Motor testing and sensory examination was within normal limits for bilateral lower extremities. Knee flexion was noted to be 135 bilaterally and extension was '0'. Diagnostic studies include x-rays of the lumbar spine, as well as an MRI of the lumbar spine. Treatment has included physical therapy, chiropractic therapy, acupuncture, aquatic therapy, a home exercise program, an electrical stimulation unit, trigger point injections of the lumbar area, lumbar facet injections, heat and cold treatment, work restrictions, and pain management. 'Moderate to severe' impairment of self-care and personal hygiene, communication, sensory function, 'non-specialized' hand function, and travel were

noted. 'Severe' impairment was noted in sexual function and sleep (7-15-15). The 8-6-15 progress record indicates that OxyContin is no longer covered by insurance. Methadone was increased from 5mg, 1 tablet twice daily as needed, to Methadone 5 mg, 1 tablet three times daily as needed. Zanaflex was also recommended to be increased from 4mg twice daily as needed to 4mg three times daily for spasms. The record indicates that the injured worker is 'no longer on Darvocet, Xodol, Nucynta, Lyrica, Amrix, Ultram, Cymbalta, and Lidoderm'. The request for authorization (8-13-15) includes Methadone 5mg, 1 tablet three time daily as needed, #90, Nucynta IR 100mg, 1 tablet three times daily as needed, #90, Zanaflex 4mg three times daily as needed for spasm, #90, a back brace, and trigger point injection. The utilization review (8-20-15) indicates denial of all requests with the following rationales: 1. Methadone and Nucynta - 'the provided medical records do not document the specifically requested information to include decreased VAS scores, appropriate monitoring with urine drug screens, and a narcotic contract'. 2. Zanaflex - 'the provided medical records do not document efficacy in terms of decreased VAS scores or that the patient is having an acute exacerbation of pain at this time'. 3. Back brace - 'the provided medical records do not document spondylolisthesis, instability, or compression fractures for which a lumbar brace would be medically necessary'. 4. Trigger point injection - 'the provided medical records do not contain sufficient information to support trigger point injections at this time'.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 5mg #90, one tab po tid prn "no refill": Overturned

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): Opioids, criteria for use. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic) / Methadone.

Decision rationale: Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, Opioids should be continued if the patient has returned to work or has improved functioning and pain. Ongoing management actions should include prescriptions from a single practitioner, taken as directed and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. Documentation should follow the 4 A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long-term users of opioids should be regularly reassessed. In the maintenance phase, the dose should not be lowered if it is working. In addition, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected when this happens opioids can actually increase rather than decrease sensitivity to noxious stimuli. It is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. Per the ODG Methadone is 'recommended as a second-line drug for moderate to severe pain, only if the potential benefit outweighs the risk, unless methadone is prescribed by pain specialists with experience in its use and by

addiction specialists, where first-line use may be appropriate. Due to the complexity of dosing and potential for adverse effects including respiratory depression and adverse cardiac events, experienced practitioners (i.e. pain medicine or addiction specialists) should reserve this drug for use. (ICSI, 2009) Methadone is considered useful for treatment when there is evidence of tolerance to other opiate agonists or when there is evidence of intractable side effects due to opiates. Limited evidence suggests there may be a role for this drug for neuropathic pain, in part secondary to the N-methyl-D-aspartate (NMDA) receptor effect.' A review of the injured workers medical records reveal long term use of opioids as well as documentation of improvement in pain and function including activities of daily living , and ongoing management actions, the continued use appears appropriate in this injured worker, therefore the request for Methadone 5mg #90, one tab po tid prn 'no refill' is medically necessary.

Nucynta IR 100mg #90, one tab po tid prn BTP "no refill": Overturned

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): Opioids, criteria for use.

Decision rationale: Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, Opioids should be continued if the patient has returned to work or has improved functioning and pain. Ongoing management actions should include prescriptions from a single practitioner, taken as directed and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. Documentation should follow the 4 A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long-term users of opioids should be regularly reassessed. In the maintenance phase the dose should not be lowered if it is working. Also, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected when this happens opioids can actually increase rather than decrease sensitivity to noxious stimuli. It is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. A review of the injured workers medical records reveal long term use of opioids as well as documentation of improvement in pain and function including activities of daily living and ongoing management actions, the continued use appears appropriate in this injured worker, therefore the request for Nucynta IR 100mg #90, one tab po tid prn BTP 'no refill' is medically necessary.

Zanaflex 4mg #90, one tab po tid prn spasm "no refill": Overturned

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): Muscle relaxants (for pain).

Decision rationale: The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include Chlorzoxazone, Methocarbamol, Dantrolene and baclofen. This medication is not recommended for long term use, however it is reported that this medication is being used on an as needed basis for spasms in the injured worker, in this context the continued use is appropriate, therefore the request for Zanaflex 4mg #90, one tab po tid prn spasm 'no refill 'is medically necessary.

Back brace: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

Decision rationale: Per ACOEM in the MTUS, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief, A review of the injured workers medical records show that she has had symptoms since 4/28/10 and is no longer in the acute phase, therefore based on the injured workers current clinical presentation and the guidelines the request for back brace is not medically necessary.

Trigger point injection: 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): Trigger point injections.

Decision rationale: Per the MTUS, Trigger point injections are recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional

painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. Per the MTUS, Criteria for the use of Trigger point injections: Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. Unfortunately the request is not associated with a quantity and location, without this information it is not possible to determine medical necessity, therefore the request for Trigger point injection is not medically necessary.