MAXIMUS Federal Services

Case Number:	CM15-0033609		
Date Assigned:	02/27/2015	Date of Injury:	09/17/2011
Decision Date:	04/13/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/23/2015

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 68 year old female with an industrial injury dated 09/17/2011. Her diagnoses include cervical spine disc protrusion with radiculitis and degenerative disc disease. Recent diagnostic testing has included a MRI of the cervical spine (10/16/2014) showing a marked left thyroid enlargement displacing the trachea, spinal straightening, disc bulges at multiple levels with contact and mild cord compression, and electrodiagnostic studies of the cervical spine/upper extremities (10/08/2014) showing moderate to severe right ulnar neuropathy. Previous treatments have included conservative measures, medications, and lumbar epidural steroid injection. In a progress note dated 01/12/2015, the treating physician reports complaints of neck pain with numbness in both hands. The objective examination revealed no changes from previous exam, which showed decreased range of motion and decreased sensation to both hands. The treating physician is requesting multiple medications, which were denied by the utilization review. On 01/27/2015, Utilization Review non-certified a prescription for methadone tablets 10mg 30 day supply #240, noting the lack of documentation to support medical necessity. The MTUS guidelines were cited. On 01/27/2015, Utilization Review non-certified a prescription for Endocet tablets 10/325mg 30 day supply #240, noting the noting the lack of documentation to support medical necessity. The MTUS guidelines were cited. On 01/27/2015, Utilization Review non-certified a prescription for Lidocaine pad 5% 30 day supply #30 with 1 refill, noting the absence of documented failure of first line therapy. The MTUS guidelines were cited. On 02/23/2015, the injured worker submitted an application for IMR for

review of methadone tablets 10mg 30 day supply #240, Endocet tablets 10/325mg 30 day supply #240, and Lidocaine pad 5% 30 day supply #30 with 1 refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone Tab 10mg day supply: 30 Qty: 240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Page(s): 61-62, 93, 75, 76-80, and 124.

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

Decision rationale: According to the 09/22/2014 report, this patient presents with ongoing severe low back pain and leg pain. The current request is for Methadone Tab 10mg day supply: 30 Qty: 240. This medication was first mentioned in the 07/21/2014 report; it is unknown exactly when the patient initially started taking this medication. The request for authorization is not included in the file for review. The patient has not reached maximum medical improvement. For chronic opiate use, 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 4A's; analgesia, ADLs, adverse side effects, and aberrant 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. According to the records made available for review, the treating physician indicates the patient "shown improved analgesia with her medications, good functional improvement, and minimal side effects. Most recent urinalysis was discussed with the patient, including the serious nature of combining narcotic medications with alcohol." Per 09/08/2014 report, the patient "rates her pain as 6 while resting and 8 with activities. The pain is associated with weakness. She is unable to perform her activities of daily living due to this pain." In this case, the report shows documentation of pain assessment using a numerical scale describing the patient's pain. Urine toxicology report was mentioned. However, there is no demonstration of "significant" improvement in ADL's. The treating physician does not mention in what specific way the ADL's or function are improved; no specific activities such as exercises, house-work, social interactions are discussed showing significant improvement due to medication use. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should be slowly weaned as outlined in MTUS Guidelines. The request IS NOT medically necessary.

Endocet Tab 10/325mg day supply: 30 Qty: 240: Upheld

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

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

Decision rationale: According to the 09/22/2014 report, this patient presents with ongoing severe low back pain and leg pain. The current request is for Methadone Tab 10mg day supply: 30 Qty: 240. This medication was first mentioned in the 07/21/2014 report; it is unknown exactly when the patient initially started taking this medication. The request for authorization is not included in the file for review. The patient has not reached maximum medical improvement. For chronic opiate use, 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 4A's; analgesia, ADLs, adverse side effects, and aberrant 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. According to the records made available for review, the treating physician indicates the patient "shown improved analgesia with her medications, good functional improvement, and minimal side effects. Most recent urinalysis was discussed with the patient, including the serious nature of combining narcotic medications with alcohol." Per 09/08/2014 report, the patient "rates her pain as 6 while resting and 8 with activities. The pain is associated with weakness. She is unable to perform her activities of daily living due to this pain." In this case, the report shows documentation of pain assessment using a numerical scale describing the patient's pain. Urine toxicology report was mentioned. However, there is no demonstration of "significant" improvement in ADL's. The treating physician does not mention in what specific way the ADL's or function are improved; no specific activities such as exercises, house-work, social interactions are discussed showing significant improvement due to medication use. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should be slowly weaned as outlined in MTUS Guidelines. The request IS NOT medically necessary.

Lidocaine Pad 5% day supply: 30 Qty: 30 Refills: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 56-57, 112.

Decision rationale: According to the 09/22/2014 report, this patient presents with ongoing severe low back pain and leg pain. The current request is for Lidocaine Pad 5% day supply: 30 Qty: 30 Refills: 1. Lidoderm patch was first mentioned in the 07/21/2014 report. The MTUS guidelines state that Lidoderm patches may be recommended for neuropathic pain that is peripheral and localized when trials of antidepressants and anti-convulsants have failed. The provided medical reports show the patient has lumbar spinal neuropathic pain but this is not a localized condition. The treating physician has not documented that a trial of anti-depressants and anti-convulsion have failed, the location of trial of the lidoderm patches is not stated. Furthermore, Lidoderm patches are not recommended for axial back pain but peripheral, localized neuropathic pain. The current request IS NOT medically necessary.