

Case Number:	CM13-0023037		
Date Assigned:	11/15/2013	Date of Injury:	03/29/1999
Decision Date:	01/21/2014	UR Denial Date:	08/30/2013
Priority:	Standard	Application Received:	09/11/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 57-year-old female who reported an injury on 03/29/1999. Report on 06/13/2013 states that the patient has a longstanding and severe low back and bilateral lower extremity symptoms as a consequence of the injuries sustained in 1999. She has undergone spinal surgery 3 times which initially was performed in 2000 and again in 2004 and 2008. The spinal cord stimulator that was implanted in 2008 in the lumbar spine region was initially effective but is no longer functioning. The patient was having persistent severe pain. Her principal symptoms include bilateral severe pain, particularly in the left sacroiliac region. Patient medications include hydrocodone, Cymbalta, Baclofen. Lidoderm patch, Flector patch, Butrans, L-thyroxine, and Simvastatin. On neurological examination, she had marked limitation of movement to her hips, left greater than the right, as well as limitation of movement of the lower spine. Patient was subsequently diagnosed with persistent severe pain due to bilateral sacroiliac joint disease, left far greater than the right. The patient underwent left sacroiliac fusion using screws and rods, nerve monitoring using NuVasive needle electrodes monitored at remote site dated 7/12/13. Current request is for 60 Tablets of Methadone 5mg between 8/29/2013 and 10/13/2013 which was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

Sixty (60) tablets of Methadone 5mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Page(s): 61-62.

Decision rationale: CA-MTUS (effective July 18, 2009) page 61 to 62, indicated that 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). Multiple potential drug-drug interactions can occur with the use of Methadone. A complete list of medications should be obtained prior to prescribing methadone to avoid adverse events, and the patient should be warned to inform any other treating physician that they are taking this medication prior to starting and/or discontinuing medications. Genetic differences appear to influence how an individual will respond to this medication. Following oral administration, significantly different blood concentrations may be obtained. Vigilance is suggested in treatment initiation, conversion from another opioid to methadone, and when titrating the methadone dose. (Weschules 2008) (Fredheim 2008). Delayed adverse effects may occur due to methadone accumulation during chronic administration. Systemic toxicity is more likely to occur in patients previously exposed to high doses of opioids. This may be related to tolerance that develops related to the N-methyl- D-aspartate (NMDA) receptor antagonist. Patients may respond to lower doses of methadone than would be expected based on this antagonism. One severe side effect is respiratory depression (which persists longer than the analgesic effect). Methadone should be given with caution to patients with decreased respiratory reserve (asthma, COPD, sleep apnea, severe obesity). QT prolongation with resultant serious arrhythmia has also been noted. Use methadone carefully in patients with cardiac hypertrophy and in patients at risk for hypokalemia (including those patients on diuretics). Methadone does have the potential for abuse. Precautions are necessary as well for employees in safety sensitive positions, including operation of a motor vehicle. Medical records submitted for review did not document the patient cardio-pulmonary functional status, baseline electrocardiography and serum potassium level before initiating methadone therapy, therefore the request for methadone 5mg was not medically necessary.