

Case Number:	CM13-0034809		
Date Assigned:	12/11/2013	Date of Injury:	06/30/2003
Decision Date:	02/05/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	10/15/2013

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 Pain Management, has a subspecialty in Disability Evaluation, 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 55 year old male with a history of chronic low back pain with radiation into the lower extremity. He is status post lumbar fusion with a date of injury of 6/30/03. In addition to the musculoskeletal complaints, there is a history of bladder cancer and associated chemotherapy and radiation. A recent evaluation by his treating physician on 8/26/13 revealed a right-sided limp, restricted lumbar and right hip ranges of motion, positive bilateral straight leg raise, decreased sensation over the right lateral calf and bottom of the right foot and lumbar sacral muscle spasms. He is currently on methadone, Norco, Soma, Mobic, Nexium, Atenolol, and Lyrica. Recent blood work showed an elevation in liver enzymes; the provider is discontinuing Norco due to the acetaminophen content, and transitioning to Oxycodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

request for 180 tablets of Oxycodone, 15mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 86-87, 92.

Decision rationale: Oxycodone immediate release is a controlled release formulation of Oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. Oxycontin tablets are not intended for "as needed" use. The Chronic Pain Medical Treatment Guidelines section on opiates recommends that dosing not exceed 120mg oral morphine equivalents per day; for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. Providers are to use the appropriate factor to determine the Morphine Equivalent Dose (MED) for each opioid. Rarely, and only after pain management consultation, should the total daily dose of opioid be increased above 120mg oral morphine equivalents. The MED factor for Oxycodone is 1.5, and the requested daily dose of Oxycodone for this patient is 90mg, which translates to 135mg oral morphine equivalents per day. This exceeds the recommended dose; therefore, Oxycodone 15 mg #180 is not medically necessary.

request for 180 tablets of Methadone 10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 61-62, 86-87.

Decision rationale: The California MTUS indicates that Methadone is recommended as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk. The FDA states 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. Therefore, Methadone should only be prescribed by providers experienced in using it. Multiple potential drug-drug interactions can occur with the use of Methadone. A complete list of medications should be obtained prior to prescribing it 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. 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). Total cardiac output (QT) prolongation with resultant serious arrhythmia has also been noted. Methadone should be used 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. The Chronic Pain Medical Treatment Guidelines section

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