MAXIMUS Federal Services

Case Number:	CM13-0041109		
Date Assigned:	12/20/2013	Date of Injury:	05/01/1999
Decision Date:	02/10/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/10/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Medicine and is licensed to practice in North Carolina. He 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 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 60-year-old male with a reported injury date of 5/1/99 that occurred when he was loading paper into a printer. There was a reported second injury when he returned to work on light duty and fell over a box of paper while carrying a 50 pound box of paper. His diagnoses include discogenic low back pain, morbid obesity, history of opiate addiction, major depression, hypertension, atrial fibrillation, peripheral edema and narcotic dependence. His listed medications included Methadone 120 mg 6x per day, soma 350 mg 1 Â½ qid, verapamil 120 mg bid, lisonopril/HCTZ 10/15/ qd, Fortesta 10mg 2 pumps qd, atenolol 75 mg qd and Coumadin 5mg qd. Progress notes from [redacted] from [redacted]. were reviewed which noted consistent bibasilar paralumbar tenderness to palpation along with decreased range of motion and peripheral edema with chronic hemosiderin discoloration. A progress noted dated 01/02/2013 notes " a methadone level and it came out at 960, which is a little bit high, but not in the toxic range." Another progress note dated 09/17/2013 notes the patient takes random drug screening to check if he is compliant with medications. A utilization review decision dated 10/04/2013 rendered a decision to certify in-patient detoxification program, functional restoration program and Fortesta. It failed to certify methadone level check.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone Level: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Inpatient Detoxification Program, Official Disability Guidelines Treatment in Workers\Comp, 9th Edition.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-78 and 61-62.

Decision rationale: The California MTUS discusses the role of drug screening in the presence of chronic opioid use as the following: On-Going Management. Actions Should Include: (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. American Pain Society and American Academy of Pain Medicine. Opioids Guidelines Panel recommends UDT routinely in patients at high risk for drug abuse, and should be "considered" in lowerâ¿ • risk patients. Official Disability Guidelines. â¿¢ "Best Practice" guidelines recommend that patients at low risk of adverse outcomes be monitored randomly at approximately every six months. A frequency of three to four times a year is recommended for patients who are at intermediate risk, are undergoing prescribed opioid changes without success, have a stable addiction disorder, are in unstable and/or dysfunctional social situations, and/or have comorbid psychiatric pathology. Patients who are at high risk of adverse outcomes may require testing as often as once a month. Methadone: 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) Pharmcokinetics: 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) Adverse effects: 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 motorvehicle. Steps for prescribing methadone: (1) Basic rules - Weigh the risks and benefits before pr