

Case Number:	CM13-0043549		
Date Assigned:	12/27/2013	Date of Injury:	05/01/1999
Decision Date:	02/21/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	10/24/2013

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:

This is a 60 year old (██████████) male computer operator with a reported date of injury on 05/01/1999. It occurred while manipulating a 50 pound item at work, apparently as a result of a twisting movement. He has had subsequent injuries as well. He is currently unable to work. The soft tissue-neck, lower back area, physical/mental, and both lower legs have been accepted by the carrier. Subsequent back pain was realized and persisted. Diagnoses include discogenic low back pain, history of opiate addiction, morbid obesity. . At that time he weighed 300 lbs. Subsequent problems include back pain, leg pains, knee pains and depression. Weight has increased to between 350 and 400 pounds in the interim. His methadone dose has been very high at 700 mg per day. He has been through 2 detoxification programs and is in line for another program to wean him from methadone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 130mg 6 times qd QTY: 180.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88, 89, 93,.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 61, 88-89.

Decision rationale: In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents according to the guideline. Rarely, and only after pain management consultation, should the total daily dose of opioid be increased above 120 mg oral morphine equivalents. (Washington, 2007). In this case, the Methadone dose is 700 mg per day which translates to 8400 morphine equivalents per day. This far exceeds the recommended dose; therefore, methadone 130mg 6 doses per day, #180 is not appropriate and is not medically necessary. CA-MTUS (effective July 18, 2009) page 61 to 62 indicates 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. Chronic Pain Medical Treatment Guidelines: 8 C.C.R. §§9792.20 - 9792.26 section on opiates recommends that dosing not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine

Methadone Level Lab Study QTY 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88, 89, 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 61, 88-89.

Decision rationale: Patient to enter detoxification program for Methadone, thus the Methadone Level Lab Study is not indicated, so not appropriate or medically necessary

