

<b>Case Number:</b>	CM14-0006266		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	07/30/2003
<b>Decision Date:</b>	07/23/2014	<b>UR Denial Date:</b>	12/31/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/14/2014

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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/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 46-year-old male with a 7/30/03 date of injury. He sustained a spinal cord injury and head trauma with resultant incomplete quadriplegia. A 1/13/14 progress note documents spasms in the cervical paraspinal muscles and notes stiffness in the cervical spine, and spasms noted in the right hand intrinsic muscles with rigidity. He is using bilateral forearm crutches for ambulation and has a stiff and antalgic gait. There is limited mobility noted in the cervical spine. The diagnostic impression indicates anterior spinal artery compression syndrome, low back pain, incomplete quadriplegia C5-C7, chronic pain, chronic depression, sleep apnea, gastroesophageal reflux disease (GERD), neurogenic bladder, erectile dysfunction, and post-traumatic brain injury. The treatment to date includes: Medication management, activity modification, physical therapy (PT) and occupational therapy (OT), psychotherapy, facet blocks, epidurals, bilateral forearm crutches, wrist and neck braces, and continuous positive airway pressure (CPAP) machine. A utilization review (UR) decision dated 12/23/13, denied the request for Methadone. The patient has not shown any significant improvement with the use of the Methadone. Also, there have been several inconsistent urine drug screen (UDS) results that showed no use, despite this opioid having an extremely long half life. The guidelines do not support the use of opioids when there are inconsistent UDS results and warns against the use of Methadone due to its potentially deadly side effects. An electrocardiogram (EKG) should be done before Methadone is provided and monitoring of the EKG should be evident with repeated EKG tests. No evidence is provided that this has been done and there is no discussion of why the Methadone is continued when the UDS showed no use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**METHADONE 5MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49, Chronic Pain Treatment Guidelines Page(s): 78-82. Decision based on Non-MTUS Citation ACOEM Guidelines, 2nd Edition, 2004, page 115.

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

**Decision rationale:** The Chronic Pain Guidelines recommend Methadone 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 four to eight (4-8) hours. Methadone should only be prescribed by providers experienced in using it. There is no documentation as to why the patient cannot tolerate a first-line opioid and why the patient is on Methadone instead. However, the urine drug screens (UDS) were inconsistent showing that Methadone was not present. These findings show misuse and aberrant behavior. The provider did not address the inconsistent UDS results. Methadone is associated with severe side effects such as respiratory depression and cardiac abnormalities. The progress notes do not indicate any functional improvement and improved activities of daily living with Methadone. It is documented that the patient has sleep apnea, and the guidelines do not support the use of Methadone in patients with decreased respiratory reserve. Therefore, the request for Methadone 5 mg #60 is not medically necessary.