

Case Number:	CM14-0156886		
Date Assigned:	09/26/2014	Date of Injury:	04/26/1977
Decision Date:	10/27/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/25/2014

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 Pain Management, 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 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:

The injured worker is a 66-year-old male who sustained an injury on 04/26/77. He has low back pain with intermittent dull aching pain radiating down to posterolateral legs. He reported pain at 4-9/10. He also has increased neck pain since his neck popped while reaching for the phone. On exam, cervical range of motion was decreased. Flexion was 30 degrees, extension was 20 degrees and rotation was 20 degrees to left and right, painful crepitus palpable at C4, C5, and C6. Lumbar flexion was limited to 30 degrees while standing and elicited pain across low back diffusely. He was unable to perform lumbar extension beyond 10 degrees and extension elicited sharp pain over lower lumbar spine. Palpation of bilateral quadratus lumborum and erector spinae muscles revealed spasm and twitching of the muscle bellies with point tenderness at various points. Sacroiliac joints were moderately tender to palpation. Neurologic exam revealed dysesthesia of lateral hands, forearms, and lateral feet. Current medications include Methadone and Gabapentin. He is allergic to Aspirin, Ibuprofen, and Tylenol. Prior treatments have included physical therapy, acupuncture, chiropractic care, and home exercise, all of which have provided pain relief. He has been on methadone since 05/07/14. He reports benefit with chronic pain medication maintenance regimen, activity restriction, and rest. Diagnoses included postlaminectomy syndrome of lumbar region, sciatica, lumbago, chronic pain syndrome, cervical facet joint pain, brachial radiculitis, lumbosacral radiculopathy, lumbar facet joint pain, and cervicgia. There was no documentation regarding magnetic resonance imaging, past surgeries, and urine drug screening. The request for Methadone 10 mg #180 was modified to #135 on 09/12/14 in accordance with medical guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 10mg #180: Upheld

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

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

Decision rationale: As per Chronic Pain Medical Treatment Guidelines, Methadone is recommended as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk. The Food and Drug Administration 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. Methadone should be given with caution to workers with decreased respiratory reserve (asthma, chronic obstructive pulmonary disease, sleep apnea, severe obesity). QT prolongation with resultant serious arrhythmia has also been noted. Methadone does have the potential for abuse. Guidelines indicate "four domains have been proposed as most relevant for ongoing monitoring of chronic pain workers on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors)." The guidelines state continuation of opioids is recommended if the worker has returned to work and if the worker has improved functioning and pain. In this case, there is no mention of ongoing attempts with physical therapy or home exercise program. There is little to no documentation of any significant improvement in pain level (i.e. visual analog scale) or function with prior use to demonstrate the efficacy of this medication. There is no evidence of urine drug test in order to monitor compliance. High dose Methadone is associated with increased risk of QT interval prolongation. There is no documentation of a baseline electrocardiogram to monitor the QT interval. The request for Methadone was previously modified to #135 tablets. The medical documents do not support continuation of the request. Therefore, the medical necessity for Methadone has not been established based on guidelines and lack of documentation.