

<b>Case Number:</b>	CM14-0170947		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	06/21/2000
<b>Decision Date:</b>	11/25/2014	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2014

### 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 Internal Medicine 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 patient is a 68 year old female who had her work injury on 6/21/00 and has been followed by a pain clinic since 2002. She has been noted to have had MRI of both neck and lumbar spine and to have had epidural steroidal injection (ESI) treatments and facet joint injections for her chronic spine pain. She has also had radiofrequency treatments to her medial branch nerves in both the cervical and lumbar spine. On 9/8/14 she complained of pain and stiffness in her neck and low back and also pain to her upper outer shoulders and to her chest. She was also noted to have suffered from depression and dyspepsia. Past medications have included Fentanyl Flexor patches, Flexeril, Ambien, Lyrica, Naprosyn, Provigil, Cymbalta, Lexapro, Skalexin, Zanaflex, Klonopin, MS Contin, Elavil, and Neurontin. The treating medical doctor (M.D.) noted that she was dependent on her narcotic pain meds to provide relief from pain and maintain her functionality and that she had no signs of drug addiction or drug seeking behavior. On 9/16/14 the UR denied use of Norco, Methadone, and Lidocaine patches.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methadone 10mg, 1 tablet by mouth 3 times a day #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61 and 62 and 27.

**Decision rationale:** The MTUS states that Methadone is a second line drug for the treatment of moderate to severe pain if the benefit outweighs the risk. It has a long half-life of 8-59 hours and its pharmacokinetics differ among individuals and differing blood concentrations may be obtained from different individuals. Therefore, its titration should be closely monitored and its best utilized in professionals trained in its use. However, the therapeutic effect only lasts from 4 to 8 hours. Its long half-life delayed side effects can occur secondary to Methadone accumulation. Respiratory depression may occur, and it should be used with caution in patients with Chronic Obstructive Pulmonary Disease (COPD), asthma, Obstructive sleep apnea (OSA), and obesity. It can also cause QT prolongation, which is a risk for serious arrhythmias. Therefore, it should be used with precaution in patients with cardiac hypertrophy and hypokalemia. The 40 mg dose should be avoided because it is only FDA approved for use in detoxification and maintenance in narcotic addiction. However, the MTUS also notes that studies have shown poor outcomes in assisted withdrawal of opioids with other opioids such as Methadone and that Buprenorphine is probably a better choice to treat opioid withdrawal. Methadone is noted to be difficult to titrate and has a long half-life which make it dangerous for adverse effects secondary to accumulation and that it is a second line drug for chronic treatment of pain. Therefore, the request is not medically necessary.

**Norco 10/325mg, 1 tablet by mouth 4 times a day as needed, #120:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75 and 91.

**Decision rationale:** Norco is noted to be a short acting opioid effective in controlling chronic pain and often used intermittently and for breakthrough pain. It is noted that it is used for moderate to moderately severe pain. The dose is limited by the Tylenol component and officially should not exceed 4 grams per day of this medicine. The most feared side effects are circulatory and respiratory depression. The most common side effects include dizziness, sedation, nausea, sweating, dry mouth, and itching. In general, opioid effectiveness is noted to be augmented with 1- education as to its benefits and limitations, 2- the employment of non-opioid treatments such as relaxation techniques and mindfulness techniques, 3- the establishment of realistic goals, and 4- encouragement of self-regulation to avoid the misuse of the medication. The MTUS notes that opioid medicines should not be the first line treatment for neuropathic pain because of the need for higher doses in this type of pain. It is also recommended that dosing in excess of the equivalent of 120 mg QD of morphine sulfate should be avoided unless there are unusual circumstances and pain management consultation has been made. It is also stated that the use of opioids in chronic back pain is effective in short term relief of pain and that long term relief of pain appears to be limited. However, the MTUS does state that these meds should be continued if the patient was noted to return to work and if there was noted to be an improvement in pain and functionality. Also, it is noted that if the medicine is effective in maintenance treatment that dose

reduction should not be done. This patient has dyspepsia and non-steroidal anti-inflammatory drugs (NSAID's) may not be the best medicine for pain control. It is note that the patient has been on a multitude of other meds recommended for pain control but has been taken off of them. Per guidelines, Norco is a good medicine for breakthrough pain and the requested med does not exceed the tolerable dose for Tylenol. Also, the M.D. is monitoring for addiction and the patient does not exhibit any drug seeking behavior. Therefore, the request is medically necessary.

**Lidoderm Patch 5%, apply 1 patch once a day #30, with 1 refill,:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Lidoderm (lidocaine patch).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56 and 57. Decision based on Non-MTUS Citation Up to date review of lidocaine

**Decision rationale:** MTUS guidelines note that Lidoderm is used for localized peripheral pain after a trial of a first line med such as tricyclic, serotonin-norepinephrine reuptake inhibitor (SNRI) or Neurontin or Lyrica has been instituted and that it is just FDA approved for treatment of post herpetic neuralgia and that further research needs to be done before it can be recommended for neuropathic pain of other etiologies. Up to Date notes that lidocaine patches have potential side effects of tachycardia, anxiety, confusion, somnolence, angioedema, and hypoxia. It also notes that lidocaine patches have been shown to be efficacious and well tolerated in treatment of post herpetic pain and also allodynia secondary to other types of peripheral neuropathic pain. It is best in localized neuropathic pain and is often used in conjunction with other medications in treatment of this type of pain. It states that neuropathic pain is often not controlled by just one medicine and often needs a combination of meds in order to be treated. Noted, this patient has been on many first line meds for pain and particularly neuropathic pain, but they have been stopped. She has been tried on Neurontin, Lyrica, Cymbalta, Lexapro, and Elavil. She has responded to Lidocaine patches without side effects. The request is medically necessary.