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| Case Number: | CM14-0175310 | | |
| Date Assigned: | 10/28/2014 | Date of Injury: | 02/02/2005 |
| Decision Date: | 12/05/2014 | UR Denial Date: | 09/26/2014 |
| Priority: | Standard | Application Received: | 10/23/2014 |

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 Psychiatry & Neurology, has a subspecialty in Addiction 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:

Records reviewed include 44 pages of medical and administrative records. The injured worker is a 58 year old male whose date of injury is 02/02/2005. He had an accident while wrestling which then lead to pain, numbness and tingling down both legs. His primary diagnosis is facet syndrome, encounter for long term use of other medications, lumbago, lumbar region post laminectomy syndrome, and cervicalgia. He had lumbar surgery in 2007, and received injections. MRI of the lumbar spine of 07/31/13 showed multilevel degenerative disk changes, disk herniations, stenosis, and arthropathy. His lower pain is constant and dull. Lumbar fusion 2009 with increasing low back pain and bilateral lower extremity radiculopathy. MRI of 10/4/14 showed good positioning of the lumbar spine with preservation of vertebral body height. On 04/25/14, he reported a "new and increasing" shooting pain down the right anterolateral knee and calf in an office visit with his provider (pain medicine consultants). He indicated that he was trying to exercise, his medications had helped, but he still felt like he was walking on broken glass. Pain was rated as 7/10 at this visit. On 05/06/14 there were no changes in symptoms. Medications included diazepam 10mg at HS prn spasm, cyclobenzaprine 7.5mg TID prn spasm, gabapentin 600mg TID, Percocet Q4H prn, and nortriptyline 10mg QHS. On 07/22/14 he noted a meaningful degree of pain relief with no adverse events. On 08/07/14 pain rating was 6/10; he was now having spasms across his back. He did not schedule an epidural as he "did not know about it". He still felt like he was walking on broken glass. He continued attempting to exercise and the meds were helping. A police report was mentioned but no details were given as to the nature of this. He was using meds appropriately with no evidence of abuse or diversion. Pain management office visit of 09/23/14, pain rated as 8/10 with reported 70% relief in back pain. Over the past 2 days the patient had noticed a sudden increase in weakness "fatigue" similar to

symptoms before surgery. He denied bowel/bladder incontinence, fever, chills. The patient was limping. Utox demonstrated compliance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone HCL 5mg #30 (times 2 refills): Upheld

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

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

Decision rationale: The patient suffers from pain ratings of 6-8/10. Methadone is recommended as a 2nd line drug for moderate to severe pain. Its long life (8-59 hours) carries with the potential for morbidity/mortality, with pain relief from this agent only lasting 4-8 hours. There is no discussion of the rationale for use of Methadone in this patient, or other agents that were tried and failed. As such this request is not medically necessary. MTUS: "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) Pharmacokinetics: 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 motor vehicle."

Baseline Pain Psych Testing BBH12-P3/Electronic Psych Testing: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 57-64; 396-397, Chronic Pain Treatment Guidelines Psychological treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Psychological evaluations Page(s): 100-101.

Decision rationale: MTUS: Recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation.