

<b>Case Number:</b>	CM14-0184483		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	04/16/2001
<b>Decision Date:</b>	12/15/2014	<b>UR Denial Date:</b>	10/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2014

### 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 New York. 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 53 year old male with a date of injury of 04/16/2001. He was moving furniture all day and bent over (no acute injury) and had low back pain. He had low back surgery in 07/2002 and 08/2002. A third surgery was done in 2003 to remove hardware. A fourth low back surgery was done in 2004. He had a L3-L4 laminectomy and L5-S1 fusion. 07/05/2005 he had a L5-S1 revision. On He has chronic low back pain. On 07/16/2007 he was taking Norco and Morphine. He has been taking Methadone since at least 12/2013. Presently he is also taking Cymbalta and Norco 10/325. On 07/30/2014 he had decreased lumbar range of motion with positive right straight leg raising. He had paralumbar muscle tenderness. On 09/30/2014 it was recommended that the patient be weaned off Methadone. He had 3-6/10 pain with medication and 6-9/10 without. This was unchanged on 10/28/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methadone 10mg:** Upheld

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

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

**Decision rationale:** Chronic Pain Medical Treatment Guidelines, MTUS (Effective July 18, 2009) Page 61, Methadone: 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. The patient has obstructive sleep apnea treated with BiPAP and Methadone is to be avoided in these patients because of its effect as a long term respiratory depressant. Therefore, the request for Methadone 10mg is not medically necessary and appropriate.