

Case Number:	CM14-0024956		
Date Assigned:	06/11/2014	Date of Injury:	04/29/2002
Decision Date:	07/15/2014	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	02/27/2014

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 Physical Medicine and Rehabilitation, 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 47-year-old who reported an injury on April 29, 2002. He reported that he was strapping a load of sheet metal onto a flatbed delivery truck when a loaded forklift came around a corner and struck him from behind, pinning/wedging him to the rear of the truck. His complaints soon developed into lower back pain, hip and pelvis pain with diffuse bruising across his pelvis and groin areas, mid back pain, neck pain and left shoulder pain. Chiropractic care yielded some relief. He attempted an unsuccessful return to work in 2003. A psychiatric evaluation in 2004 noted extensive depression due to his injury. On October 12, 2004 he reported constant lower back pain radiating into his legs, weakness in the left knee and ankle and soreness of his hips. His cervical range of motion (ROM) measured in degrees was flexion 60/70, extension 30/30, right lateral flexion 40/70, left lateral flexion 40/70, right rotation 60/70, left rotation 60/70. Lumbar ROM was flexion 50/70, extension, right and left lateral flexion and rotation were within normal limits. An MRI of February 18, 2004 showed mild disc desiccation at the L4-5, L5-S1 level with annular type disc bulging and mild facet hypertrophy but no canal stenosis or foraminal narrowing. There were no acute or sub-acute bony abnormalities of the left knee with intact menisci, tendons and ligaments without joint effusion. In the cervical spine there was only minor spondylitic/degenerative changes with no focal protrusions, canal stenosis or foraminal narrowing at any level. On June 3, 2014, this worker continues to report ongoing persistent pain in the lower back, gluteal area, arms, legs neck and thighs. He said that his symptoms are relieved by exercise, heat, lying down, massage, pain medications, physical therapy, stretching and rest. He rated his general pain 9/10 without medications and 6/10 with them. His medications included Prilosec 20 mg, methadone 10 mg, klonopin 0.5 mg, androgl 1% 50 mg/5 grams and abilify 5 mg. There was no request for authorization found in this chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

METHADONE HCL 10MG #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 61-62, 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: This 47-year-old reported that on April 29, 2002 he was wedged between a forklift and a flatbed truck. He developed lower back pain, hip and pelvis pain with diffuse bruising across his pelvis and groin areas, mid back pain, neck pain and left shoulder pain. After twelve years he reported ongoing persistent pain in the lower back, gluteal area, arms, legs neck and thighs. He had been treated pharmacologically with methadone over an extended period of time. The Chronic Pain Medical Treatment Guidelines attests that opioid drugs are considered the most powerful class of analgesics that may be used to manage chronic pain. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The monitoring of outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. To aid in pain functioning assessment. Opioids should be continued if the patient has returned to work or if the patient has improved functioning and pain. Under the subheading Opioids for Chronic Pain, the recommendations read opioids have been suggested for neuropathic pain that has not responded to first-line recommendations (antidepressants, anticonvulsants). There are no trials of long-term use. There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant neuropathy. For chronic back pain, opioids appear to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (greater than sixteen weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In most cases, analgesic treatment should begin with acetaminophen, aspirin and NSAIDs (non-steroidal anti-inflammatory drugs). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern for the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (less than seventy days). This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. In considering long-term safety of opioids, this has not been systematically studied. Long-term use may result in immunological and endocrine problems. There is no documentation in the submitted chart to attest to appropriate long-term monitoring, evaluations, side effects, drug screens or collateral contacts. Although the

worker is taking an antidepressant medication, there is no evidence of failed aspirin, NSAID or anticonvulsant trials. The worker has been taking methadone for a greater period than the recommended sixteen weeks. The request for Methadone HCL 10mg, 150 count, is not medically necessary or appropriate.