

<b>Case Number:</b>	CM14-0041403		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	03/08/1986
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	03/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/14/2014

### 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 Family 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 worker is a 60 year old male who was injured in 1986 after being struck by plywood and subsequently fell 13 feet, landing on his feet. He later developed chronic pain related to the incident. He was diagnosed with compression fracture of the thoracic spine, cervical myelopathy and radiculopathy as well as axial back pain related to degenerative disc disease and facet disease. Treatments have been conservative therapies including oral medications and chiropractor treatments, as well as epidural epidural and trigger injections, and surgery (cervical). He was seen on 9/30/13 by his new treating physician reporting using (started by a previous physician) Norco 10/325 mg every 4-5 hours, gabapentin, cyclobenzaprine, trazodone, lovastatin, and methadone 30 mg twice daily. He was represcribed his same doses of his medications. On 12/4/13 he reported to his treating physician of worsening pain and was using up to 8-10 Norco per day as well as a higher frequency of his methadone to 30 mg three times per day. The new frequencies were agreed upon by the treating physician and they were prescribed and continued up to the time of the request for renewal of methadone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prospective request for 1 prescription of Methadone HCL 10 mg:** Upheld

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

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

**Decision rationale:** The MTUS Chronic Pain Guidelines state that methadone is recommended as a second-line drug for moderate to severe pain if the potential benefits outweigh the risks as there has been reported severe cases of mobility and mortality associated with its use. Methadone should only be prescribed by providers experienced in using it and caution should be used when prescribing methadone in patients with respiratory conditions, history of prolonged QT syndrome, or cardiac hypertrophy. The MTUS also states that methadone use for the treatment of opiate agonist dependence is not recommended as a first choice, as Buprenorphine is known to cause a milder withdrawal syndrome compared to methadone, yet is equally as effective as methadone. Unless there is a specific contraindication to Buprenorphine, it should be considered first when considering a treatment for opiate agonist dependence. Additional recommended steps for methadone prescribing besides weighing risks and benefits for the individual include (MTUS Guidelines): avoid prescribing 40 mg tablets for chronic pain (only for detoxification and maintenance of narcotic addiction), closely monitor patients, assess for dizziness, irregular heartbeat, or fainting, do not take extra tablets if pain isn't controlled, and a complete review of potential drug interactions is required prior to initiation. The MTUS Chronic Pain Medical Treatment Guidelines also require that for opioid use, there is to be ongoing review and documentation of pain relief, functional status, appropriate medication use with implementation of a signed opioid contract, drug screening, review of non-opioid means of pain control, using the lowest possible dose, making sure prescriptions are from a single practitioner and pharmacy, and side effects, as well as consultation with pain specialist if after 3 months unsuccessful with opioid use, all in order to improve function as criteria necessary to support the medical necessity of opioids. Long-term use and continuation of opioids requires this comprehensive review with documentation to justify continuation. Also, the MTUS Chronic Pain Guidelines recommend that dosing of opioids not exceed 120 mg or oral morphine equivalents per day, and only with a pain specialist would exceeding this amount be considered. Continuation of opioids may be recommended when the patient has returned to work and/or if the patient has improved function and pain. In the case of this worker, the dose limit for opioid use was surpassed by the recommended daily limit according to the records available for review. No quantifiable functional or pain benefits were documented in the notes available for review in order to justify continuation of methadone, and especially considering the potential risks associated with its use it is recommended to consider weaning off of the methadone. Therefore the methadone 10 mg is not medically necessary.