

Case Number:	CM15-0003501		
Date Assigned:	01/14/2015	Date of Injury:	07/19/2000
Decision Date:	03/17/2015	UR Denial Date:	12/26/2014
Priority:	Standard	Application Received:	01/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 53-year-old Female was injured in a motor vehicle accident on 7/19/2000. The diagnoses have included lumbago, myofascial pain syndrome/fibromyalgia, post laminectomy syndrome, and cervical pain with history of MRSA infection of the spine with resultant cauda equina syndrome and paraplegia. Treatment to date has included surgery, acupuncture, physical therapy, and medications. Currently, the patient complains of low back pain and bilateral legs pain that is 4/10 with medications and 10/10 without medications, along with right ankle pain. Records review that the patient has been taking Norco, Xanax, Roxicodone, Valium and methadone since at least 7/25/12. The dosage of methadone has remained stable during that time at 30 mg every 6 hours. The provider obtains frequent urine drug screens, several of which have been inconsistent, and on which the provider has never commented. In particular, screens done 7/8/13 and 9/3/13 were negative for oxycodone, which the patient was documented as taking at the time. The patient's functional status has not changed since 7/25/14. She ambulates with a walker, and is able to drive. She is unable to work in the garden or do housework. Many of the progress notes exhort her to "continue efforts at exercise", which she appears not to have done, in part because of chronic skin infections. On 12/26/2014 Utilization Review non-certified Methadone 10mg #360 modified to #51 for weaning purposes, with citation of MTUS Chronic Pain Treatment Guidelines, Opioids. On 1/7/2015 an application for IMR was submitted for review of Methadone 10mg #360 modified to #51.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 10 mg, 360 count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids - Criteria for use, Ongoing Management, and Weaning of Med.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, page 60; Criteria for use of Opioids, pages 76-77; Opioids for neur.

Decision rationale: Methadone is an opioid analgesic. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The remaining guidelines state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. The clinical findings in this case do not demonstrate that any of the above guidelines have been followed. There is no documentation that methadone was introduced individually, with ongoing careful assessment of function. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. The diagnosis of sciatic suggests that much of her pain may be neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was made of whether or not opioid use was likely to be helpful in this patient, or of her potential for abuse. Inconsistent drug screens that showed she was not taking prescribe oxycodone should have at least generated an investigation of whether or not the patient was diverting this medication. No specific functional goals were set or followed. Most importantly, methodone was not discontinued when it became clear that it has not produced any functional improvement. There is no documentation of any improvement in this patient's level of function for the past 18 months. She totally disabled, and makes minimal attempts to exercise. This is more than adequate evidence that this patient is not responding appropriately to this medication, and that it should be discontinued. Based on the evidence-based guidelines cited above, and the clinical documentation provided for my review methadone 10 mg #360 is not medically necessary for this patient. It is not medically necessary because of the lack of appropriate documentation of the patient's status prior to beginning it, because of the failure to set and monitor functional goals, because of the failure to address inconsistent drug screens and the possibility of diversion, and because of the failure to discontinue methadone when it became clear that it has not produced any functional recovery.