

<b>Case Number:</b>	CM15-0185455		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	02/26/1998
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	09/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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: New Jersey

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 is a 52 year old male with a date of injury of February 26, 1998. A review of the medical records indicates that the injured worker is undergoing treatment for post laminectomy pain syndrome with chronic lumbar radiculitis, possible retained hardware syndrome, diabetes mellitus, and major depressive disorder. Medical records dated July 20, 2015 indicate that the injured worker had been able to slowly decrease his Methadone, but that the Methadone significantly improved the pain and allowed the injured worker to be more active. A progress note dated August 24, 2015 notes the injured worker had returned for medication management, and that he was not tolerating the medication weaning. Records also indicate that the injured worker had fallen recently and complained of pain in the right side of the ribs in multiple areas. Per the treating physician (August 24, 2015), the employee's work status was listed as permanent and stationary. The physical exam dated July 20, 2015 reveals use of a cane, limited range of motion of the lumbar spine, referred back pain with straight leg raises, and bilateral distal leg weakness. The progress note dated August 24, 2015 documented a physical examination that showed no changes in the lumbar spine examination since the examination documented on July 20, 2015. The injured worker also had diffuse tenderness to the ribs on the right side. Treatment has included lumbar spine surgery, spinal cord stimulator, and medications (Lyrica 100mg three times a day, and Ultram 50mg twice a day since at least December of 2014; Methadone 10mg that was decreased from three times a day to twice a day in July of 2015). A urine drug screen collected on June 8, 2015 showed appropriate results for the prescribed medications. The original utilization review (September 6, 2015) non-certified a request for Methadone 10mg #41 and Lyrica 100mg #90.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Methadone 10mg, #41:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Methadone, Opioids, criteria for use, Opioids, long-term assessment, Weaning of Medications.

**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 have been reported severe cases of morbidity 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. Also, The MTUS Chronic Pain Medical Treatment Guidelines state that opioids, in general, may be considered for moderate to severe chronic pain as a secondary treatment, but require that for continued 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 (when appropriate), 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. Weaning opioids should include the following: complete evaluation of treatment, comorbidity, and psychological condition, clear written instructions should be given to the patient and family, refer to pain specialist if tapering is difficult, taper by 20-50% per week of the original dose for patients who are not addicted or 10% every 2-4 weeks with slowing reductions once 1/3 of the initial dose is reached, switching to longer-acting opioids may be more successful, and office visits should occur on a weekly basis with assessments for withdrawal. In the case of this worker, there was insufficient evidence to clearly support the ongoing use of 10 mg of methadone twice daily and weaning was initiated with the interest of the worker, although weaning caused some increase in pain over the last few months. Over the prior month, 41 pills were approved and a request for another month of 41 pills of methadone was made in the setting of increased pain and a new injury of his ribs. In the opinion of this worker, additional weaning is appropriate over the next many months (slow), however, considering the recent decrease in

pills, increase in pain, and new injury, postponing further reductions in number of pills prescribed can be made from another month or so. Therefore, the request for 41 pills of methadone 10 mg is medically necessary at this time.

**Lyrica 100mg, #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Acute & chronic) Pregabalin (Lyrica) 2015.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs).

**Decision rationale:** The MTUS Guidelines state that anti-epilepsy drugs (or anti-convulsants) are recommended as first line therapy for neuropathic pain as long as there is at least a 30% reduction in pain. If less than 30% reduction in pain is observed with use, then switching to another medication or combining with another agent is advised. Documentation of pain relief, improvement in function, and side effects is required for continual use. Preconception counseling is advised for women of childbearing years before use, and this must be documented. In the case of this worker, upon review of the documents provided for review, there was no statement which suggested a decrease in pain and symptoms by at least 30% directly from the use of Lyrica, although it was used regularly for many months leading up to this request for continuation. Unfortunately, without this evidence of measurable benefit and compliance with the Guidelines, this request is not medically necessary at this time until this report is found in the notes in the future.