

<b>Case Number:</b>	CM15-0198466		
<b>Date Assigned:</b>	10/13/2015	<b>Date of Injury:</b>	06/10/2003
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	10/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2015

### 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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 54 year old male, who sustained an industrial injury on 6-10-2003. Diagnoses include neck pain, mechanical axial low back pain, potentially L5-S1 facet versus disc. On 8-24-15, he complained of chronic pain in the neck and low back. Current medications listed included Methadone (50, 40, 40, 50), Oxy IR (up to five times a day), Valium (three times a day), Celebrex (twice daily), and Lidoderm patches, since at least May 2015. Pain was rated 5 out of 10 VAS with medication. It was documented that medications increased functional abilities, improved mood, and improved sleep. The physical examination documented restricted range of motion of the cervical spine with cervicogenic headaches and right occipital neuralgia. There was restricted range of motion noted in the lumbosacral spine. The plan of care included a new prescription for physical therapy, continuation of medication therapy, and possible epidural steroid injections. On 9-23-15, there was no change in chronic pain complaints. There were no new acute physical findings documented. The plan of care included ongoing medication therapy. The appeal requested authorization for Methadone 10mg #540, Oxy IR 30mg #150, Valium 10mg #90, and Relpax 20mg #20. The Utilization Review dated 10-1-15, modified the request to allow Methadone 10mg #100, Oxy IR 30mg #27, and Valium 10mg #15, and denied the Relpax 20mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methadone 10mg qty: 540: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Methadone, Opioids for chronic pain.

**Decision rationale:** This claimant was injured in 2003 and has diagnoses of neck pain, mechanical axial low back pain, and potentially L5-S1 facet versus disc pathology. There is chronic pain in the neck and low back. The medicines have been taken since at least May 2015. Pain was rated 5 out of 10 VAS with medication. It was documented that medications increased functional abilities, improved mood, and improved sleep, but there is no objective quantification of those improvements. As of September, despite the regimen, there was no change in chronic pain complaints. The MTUS notes that Methadone is 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). Multiple potential drug-drug interactions can occur with the use of Methadone. Moreover, in regards to the long term use of opiates, the MTUS poses several analytical questions such as has the diagnosis changed, what other medications is the patient taking, are they effective, producing side effects, what treatments have been attempted since the use of opioids, and what is the documentation of pain and functional improvement and compare to baseline. These are important issues, and they have not been addressed in this case. There especially is no documentation of functional improvement with the regimen. It is not clear from the records that the Methadone used in this claimant is a second line drug, and the multiple drug-drug interactions had been addressed. Further, the MTUS issues in regards to long-term opiate usage is not addressed. The request was appropriately not medically necessary.

**Oxy IR 30mg qty: 150: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** As shared previously, this claimant was injured in 2003 with neck pain, mechanical axial low back pain, and potentially L5-S1 facet versus disc pathology. There was chronic pain in the neck and low back. The medicines had been since at least May 2015. Pain was rated 5 out of 10 on the Visual Analogue Scale, with medication. It was documented that medications increased functional abilities, improved mood, and improved sleep, but no objective quantification of such improvements are noted. As of September, despite the regimen, there was no change in chronic pain complaints. The current California web-based MTUS collection was

reviewed in addressing this request. They note in the Chronic Pain section: When to Discontinue Opioids: Weaning should occur under direct ongoing medical supervision as a slow taper except for the below mentioned possible indications for immediate discontinuation. They should be discontinued: (a) If there is no overall improvement in function, unless there are extenuating circumstances. When to Continue Opioids: (a) If the patient has returned to work (b) If the patient has improved functioning and pain. In the clinical records provided, it is not clearly evident these key criteria have been met in this case. Moreover, in regards to the long term use of opiates, the MTUS also poses several analytical necessity questions such as: has the diagnosis changed, what other medications is the patient taking, are they effective, producing side effects, what treatments have been attempted since the use of opioids, and what is the documentation of pain and functional improvement and compare to baseline. These are important issues, and they have not been addressed in this case. As shared earlier, there especially is no documentation of functional improvement with the regimen.

**Valium 10mg qty: 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, under Benzodiazepines.

**Decision rationale:** As previously noted, this claimant was injured in 2003 with neck pain, mechanical axial low back pain, and potentially L5-S1 facet versus disc. There was chronic pain in the neck and low back. The medicines have been taken since at least May 2015. Pain was rated 5 out of 10 on the Visual Analogue Scale with medication. It was documented that the medications increased functional abilities, improved mood, and improved sleep. As of September, despite the regimen, there was no change in chronic pain complaints. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Regarding benzodiazepine medications, the ODG notes in the Pain section: Not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks. In this case, it appears the usage is long term, which is unsupported in the guidelines. There is no documentation of acute muscle spasm, or anxiety issues. The objective benefit from the medicine is not disclosed. The side effects are not discussed. The request is appropriately not medically necessary following the evidence-based guideline.

**Relpax 20mg qty: 20:** 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) - Treatment for Workers' Comp 2012 on the web ([www.odgtreatment.com](http://www.odgtreatment.com)). Work Loss Data Institute ([www.worklossdata.com](http://www.worklossdata.com)): Triptan.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head section, under Triptans.

**Decision rationale:** In this final review, once again, this claimant was injured in 2003 with neck pain, mechanical axial low back pain, and potentially L5-S1 facet versus disc. There is chronic pain in the neck and low back. The medicines have been since at least May 2015. Pain was rated 5 out of 10 on the Visual Analogue Scale with medication. It was documented that medications increased functional abilities, improved mood, and improved sleep. As of September, despite the regimen, there was no change in chronic pain complaints per the documentation. The MTUS is silent on this medicine. The ODG notes that this medicine is recommended for migraine sufferers. At marketed doses, all oral triptans like Relpax are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients. A poor response to one triptan does not predict a poor response to other agents in that class. (Adelman, 2003) (Ashcroft, 2004) (Belsey, 2004) (Brandes 2005) (Diener, 2005) (Ferrari, 2003) (Gerth, 2001) (Mannix, 2005) (Martin 2005) (McCrory, 2003) (Moschiano, 2005) (Moskowitz, 1992) (Sheftell, 2005). In this case, there is no classic neurologic description of migraines headaches in this claimant, which is what this medicine is effective for. The use of the medicine for injury related headache pain would be off label, and not proven effective in large-scale clinical studies. The request was appropriately not medically necessary.