MAXIMUS Federal Services

Case Number:	CM14-0095656		
Date Assigned:	07/25/2014	Date of Injury:	12/19/1977
Decision Date:	09/15/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/20/2014

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 & 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 74-year-old female who reported an injury on 12/19/1977 from an unspecified cause of injury. The injured worker had a history of lower back pain. The injured worker had a diagnosis of post lumbar laminect syndrome, lumbar degenerative disc disease, and chronic back pain. The past surgical procedures included a posterior fusion at the L4-5 and L5-S1. The MRI dated 09/02/2011 of the lumbar spine revealed straightening of the normal lumbar stenosis, an old superior endplate deformity at the L5, narrowing of the L2-3 and L3-4 and at L5-S1 disc interspaces, sclerosis of the endplates surrounding the L3-4 disc space narrowing and prior posterior fusion of the L4-5 and L5-S1. No past treatments available for review. The objective findings dated 05/09/2014 of the lumbar spine revealed loss of normal lordosis with straightening of the lumbar spine, range of motion restricted, with a flexion of 55 degrees, extension limited at 10 degrees. Palpation to the paravertebral muscle revealed spasm, tenderness, and tight muscle band bilaterally, straight leg raising was negative. The sensory examination revealed pinprick decreased at the L5-S1 dermatomes. The medications included Norflex 100 mg, Methadone 10 mg, AcipHex 20 mg, Amlodipine Besylate 10 mg, Coumadin 8 mg, Melatonin 6 mg, Salagen 5 mg, Valium 5 mg, Ambien 10 mg, and Prozac 20 mg. The treatment plan included a 4 week follow-up, continued pain medication, continued to use the transcutaneous electrical nerve stimulation (TENS) unit, and stretching program. The Request for authorization dated 01/13/2014 was submitted with documentation. The rationale for the Methadone 10 mg tablets was to control her pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

180 Methadone 10mg tablet: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Page(s): 62.

Decision rationale: The request for 180 Methadone 10 mg tablets is not medically necessary. The CA MTUS guidelines recommend methadone 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. Genetic differences appear to influence how an individual will respond to this medication. Following oral administration, significantly different blood concentrations may be obtained. Vigilance is suggested in treatment initiation, conversion from another opioid to Methadone, and when titrating the Methadone dose. Delayed adverse effects may occur due to Methadone accumulation during chronic administration. Systemic toxicity is more likely to occur in patients previously exposed to high doses of opioids. This may be related to tolerance that develops related to the N-methyl- D-aspartate (NMDA) receptor antagonist. Patients may respond to lower doses of methadone than would be expected based on this antagonism. One severe side effect is respiratory depression (which persists longer than the analgesic effect). Methadone should be given with caution to patients with decreased respiratory reserve (asthma, COPD, sleep apnea, severe obesity). QT prolongation with resultant serious arrhythmia has also been noted. Use methadone carefully in patients with cardiac hypertrophy and in patients at risk for hypokalemia (including those patients on diuretics). Methadone does have the potential for abuse. Precautions are necessary as well for employees in safety sensitive positions, including operation of a motor vehicle. Per the clinical notes provided dated 05/09/2014 no measurable pain scale was documented after the medication was reduced. Per the documentation provided, the injured worker gets good relief with her TENS unit. The injured worker was also noted as the caretaker for her ill husband. Per the 05/09/2014 Clinical Notes, the injured worker had an inconsistent urinalysis. The request did not indicate the frequency. As such, the request is not medically necessary.