

Case Number:	CM15-0111543		
Date Assigned:	06/18/2015	Date of Injury:	03/23/1999
Decision Date:	07/17/2015	UR Denial Date:	05/14/2015
Priority:	Standard	Application Received:	06/09/2015

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: North Carolina
 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:

The injured worker is a 62 year old female who sustained an industrial injury on 3/23/99 who complains of neck pain and low back pain. Diagnoses are post laminectomy-lumbar, lumbar or thoracic radiculopathy, lumbar spondylosis, history of Diabetes Mellitus. In a pain management re-evaluation report dated 5/6/15, the treating physician notes the injured worker reports constant numbness and tingling in legs and feet and is having more pain in the last month with increasing locking episodes and several falls since the last visit due to progressive weakening in her legs. She has difficulty stepping onto curbs or going up steps. Pain is described as 8 out of 10 which is an increase since the last visit. Lumbar pain is stabbing, throbbing, pressure, aching, and shooting and radiates into her legs. Her pain is improved with medications and heat and worsened with housework and prolonged repetitive activity. She has associated numbness, burning and tingling that she states is worsened with activity and improved with medication and rest. She also notes lower leg spasm at night which is controlled with valium and aggravated by nothing in particular. Methadone 5 mg works in 15 minutes, relieving 35% for 2 hours. She is able to perform activities of daily living such as self care, some minimal cleaning, home stretching and strengthening and walking for 30 minutes. Adverse effects are tiredness, so she does not drive and constipation, but she manages because pain relief is significant. Failed medications are noted to be Norco, Percocet, Flexeril and Gabapentin. Straight leg raise is negative bilaterally and there is decreased sensation of the right lateral calf and left medial foot. In a treating progress note dated 12/17/14, the treating physician notes a prescription refill for Methadone 5 mg 3 tablets three times a day for a quantity of 243 to begin weaning down slowly, the prior month notes a quantity of 270. the progress report dated 2/11/15 notes pain has increased in her low back and down legs since the last visit, the wean was too much and she asked to return to a quantity of 270 as before and pursue the wean again later after she returns

from travelling. These medications have affected her dentation, as a result of xerostomia and she will need further dental care as a result. The last EKG was done 4/2012 and was normal and are awaiting an updated one. Previous treatment includes at least 12 acupuncture sessions, Valium, Ativan, Methadone HCL, Norco, Percocet, Flexeril, Gabapentin, lumbar epidural and nerve blocks without significant relief, spinal cord stimulator with complications-removed 2002, and a lumbar brace. A urine drug screen done 4/17/14 was positively appropriate. Current medications are Methadone HCL 5 mg 3 tablets 3 times a day for pain, Valium 5 mg 1 tablet daily for muscle spasms, sleep and anxiety, Ambien 10 mg 1-2 tablets each night for sleep. The treatment plan is to continue medications for chronic pain, request a new MRI, request a replacement back brace, and obtain a urine drug screen on the next visit. The treatment requested is Methadone 5 mg #240.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Methadone 5mg, #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone; Opioids, dosing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines methadone Page(s): 61-62.

Decision rationale: The California chronic pain medical treatment guidelines section on methadone states: Methadone: 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) Steps for prescribing methadone: (1) Basic rules: Weigh the risks and benefits before prescribing methadone. Avoid prescribing 40 mg Methadone tablets for chronic non-malignant pain. This product is only FDA-approved for detoxification and maintenance of narcotic addiction. Closely monitor patients who receive methadone, especially during treatment initiation and dose adjustments. (2) Know the information that is vital to give the patient: Don't be tempted to take more methadone than prescribed if you are not getting pain relief. This can lead to a dangerous build-up that can cause death. All changes in methadone dose should be made by your treating practitioner. Methadone can make your breath slow down, or actually stop. Methadone can slow down your heartbeat and you might not be able to detect this. If you feel like you are having an irregular heartbeat, dizziness, light-headedness or fainting, call your doctor or clinic immediately. (FDA, 2006) (3) Be familiar with the current SAMHSA health advisory on methadone. The medication has become more accessible to unauthorized users. It can accumulate in potentially harmful doses (especially during the first few days of treatment. There has been a rise in Methadone-associated mortality. (SAMHSA, 2004) (4) Be familiar with

the FDA final policy statement on Methadone that explicitly discusses the topic, "Can Methadone be used for pain control?" No separate registration is required to prescribe methadone for treatment of pain. (DEA, 2006) (5) Read the new prescribing information for Methadone and the new patient information section. (Roxane, 2006) (6) Multiple potential drug-drug interactions can occur with the use of Methadone. A complete list of medications should be obtained prior to prescribing methadone to avoid adverse events, and the patient should be warned to inform any other treating physician that they are taking this medication prior to starting and/or discontinuing medications. This medication is indicated as a second-line agent in the treatment of chronic pain. The long-term use of opioid therapy is only indicated when measurable outcomes in pain control and function have been achieved. The included clinical documentation for review does not show failure of all first line pain agents. The provided documentation fails to show these measurable outcome improvements. Therefore the request has not met criteria as per the California MTUS guidelines and is not medically necessary.