

Case Number:	CM13-0035965		
Date Assigned:	12/13/2013	Date of Injury:	07/30/2003
Decision Date:	02/19/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice 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 physician 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 patient is a 46-year-old male who reported an injury on 07/30/2003, due to a fall. This resulted in injuries to include paralysis of the bilateral upper and lower extremities, closed head trauma, and a fracture of the C6-7. The patient's treatment history included epidural steroid injections, medications, and a bilateral C5-T2 posterior fusion with iliac crest graft. The patient's most recent clinical evaluation revealed no motor function in either lower extremity or neuropathic pain in the right upper extremity with possible chronic regional pain syndrome. The patient's diagnoses included anterior spinal artery compression syndrome, low back pain, neck pain, quadriplegia, and chronic pain. The patient's treatment plan included continuation of medications to include cyclobenzaprine, clonazepam, Lunesta, methadone, Nucynta, and Topamax.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 5mg tablet, 5mg 1 tablet by mouth every 12 hours, #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 78.

Decision rationale: The requested methadone 5 mg tablets, 5 mg 1 tablet by mouth every 12 hours, #20 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has chronic pain complaints related to the compensable injury. California Medical Treatment Utilization Schedule recommends the continued use of opioids in the management of a patient's chronic pain be supported by a quantitative assessment of pain relief, documentation of increased functional benefit, monitoring for aberrant behavior, and management of side effects. The clinical documentation submitted for review does not provide any evidence that the patient has a quantitative pain assessment related to this medication. Additionally, there is no documentation that the patient has significant functional benefit or is monitored for aberrant behavior. The last urine drug screen submitted for review was from 11/2012, and had inconsistent results. As there is no indication of pain relief, functional benefit, or medication compliance, continued use of this medication would not be supported by guideline recommendations. As such, the requested methadone 5 mg tablets, 5 mg 1 tablet by mouth every 12 hours, #20 is not medically necessary or appropriate.