

Case Number:	CM13-0044847		
Date Assigned:	12/27/2013	Date of Injury:	10/21/2002
Decision Date:	02/27/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	10/29/2013

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 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 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 58-year-old male who reported an injury on 10/21/2002. The mechanism of injury was not provided for review. The patient's injury ultimately resulted in a lumbar fusion. The patient's pain was managed with multiple medications. The patient was monitored for aberrant behavior with urine drug screens that were consistent. The patient's medications included Celebrex 200 mg, Lexapro 20 mg, Neurontin 600 mg, methadone HCl 10 mg, Lidoderm 5% patch, tizanidine 4 mg. The patient's diagnoses included lumbar radiculopathy, lumbar discogenic spine pain, lumbar facet arthropathy, lumbar chronic sprain/strain. The patient's treatment plan included continuation of medications and participation in a home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Methadone HCL 10mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-going Management and Opioids, dosing Page(s): 78 and 86.

Decision rationale: The requested prescription of methadone HCl 10 mg #120 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended period of time. The California Medical Treatment Utilization Schedule recommends continued use of opioids in the management of a patient's chronic pain be supported by a quantitative assessment of pain relief, documentation of functional benefit, managed side effects, and evidence of monitoring for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient has been monitored for aberrant behavior. However, the clinical documentation submitted for review does not provide any evidence of a quantitative assessment of pain relief and specific documentation of functional benefit. Additionally, the requested dose exceeds the California Medical Treatment Utilization Schedule's recommended 120 morphine equivalent dosage. As the provided documentation does not include a quantitative assessment of pain relief, the document functional benefit, and the dosage exceeds the recommended daily morphine equivalent dosage, continued use would not be supported. As such, the requested 1 prescription of methadone HCl 10 mg #120 is not medically necessary or appropriate.