

<b>Case Number:</b>	CM13-0050464		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	01/05/2003
<b>Decision Date:</b>	03/11/2014	<b>UR Denial Date:</b>	11/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2013

### 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 Ohio and Texas. He/she has been in active clinical practice for more than five years and is currently working least at 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 41-year-old male who reported an injury on 01/05/2003 due to lifting a heavy object. The patient reportedly injured his low back. The patient developed chronic pain that was managed by medications. The patient's medications included Lunesta, methadone, Nexium, Norco 10/325 mg, Soma and Zoloft as well as Topamax. The patient was monitored for aberrant behavior with regular urine drug screens. The patient's most recent clinical evaluation documented that the claimant had 8/10 to 9/10 pain of the low back that radiated into the lower extremities. Physical findings included tenderness and spasming along the lumbar paraspinal musculature with decreased sensation in the right L5-S1 dermatomes. The patient's diagnoses included low back pain, facet syndrome, lumbosacral radiculopathy, chronic pain syndrome and depression. The patient's treatment plan included the continuation of medications and the use of an H-wave therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methadose (Methadone) 10mg #290:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

**Decision rationale:** The requested Methadose (methadone) 10 mg #290 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 duration of time. However, the California Medical Treatment Utilization Schedule recommends that continued use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, documentation of functional benefit, managed side effects and evidence that the patient is monitored for compliance to the prescribed medication schedule. The clinical documentation submitted for review does provide evidence that the patient has regularly consistent urine drug screens. However, the patient's clinical examination findings do not provide any evidence of pain relief or functional benefit related to the patient's medication usage. Therefore, the continued use of Methadose would not be indicated. As such, the requested Methadose (methadone) 10 mg #290 is not medically necessary or appropriate.