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| Case Number: | CM13-0070361 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 10/14/2009 |
| Decision Date: | 06/04/2014 | UR Denial Date: | 12/11/2013 |
| Priority: | Standard | Application Received: | 12/24/2013 |

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 and Rehabilitation, and is licensed to practice in Illinois. 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 46-year-old who reported an injury on October 14, 2009 secondary to repetitive motion. The diagnoses included cervical and thoracic strain and spasm. The exam dated December 4, 2013 noted 5-6/10 pain level; however, the evaluation was handwritten and the rest of the assessment was hard to read. The treatment plan included continued medication therapy and chiropractic therapy. The request for authorization was not found in the documentation provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE OXYCOONE 10/325MG, THREE TIMES DAILY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence of an objective assessment of the injured workers

pain level, functional status, evaluation of risk for aberrant drug use behavior and side effects. Furthermore, the request does not indicate the total number of tablets requested. The retrospective request for oxycodone 10/325mg, three times daily, is not medically necessary or appropriate.

RETROSPECTIVE METHADONE 10MG, TWICE DAILY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence of an objective assessment of the injured workers pain level, functional status, evaluation of risk for aberrant drug use behavior and side effects. Furthermore, the request does not indicate the total number of tablets requested. The retrospective request for methadone 10mg, twice daily, is not medically necessary or appropriate.