

Case Number:	CM13-0071620		
Date Assigned:	01/08/2014	Date of Injury:	03/08/2000
Decision Date:	07/02/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/30/2013

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 Internal Medicine, 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 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 patient is a 55 year old male who was injured on 3/8/00. The mechanism of injury was not provided for review. Prior treatment history has included Senna, methadone, Promethazine HCL, Flexeril, and Meloxicam. A toxicology report dated 10/24/13 revealed that the patient was compliant with the medication regimen. There was no evidence of drug abuse. A PR-2 dated 11/21/13 documented that the patient complained of low back pain which she rated at 5/10, at its worse an 8/10. She reported that her pain is aggravated by sitting, and alleviated by rest and medication. Objective findings on exam revealed tenderness to palpation at L4-L5, and moderately severe bilateral lumbar spasms with tenderness to palpation to the left sacroiliac joint. The lumbar spine range of motion exhibits forward flexion to 65, hyperextension to 20, and lateral bend to 20 bilaterally. Straight leg raise test was negative bilaterally. He has a normal gait with spasm in the left lumbar region. Motor and sensory exams are normal in the bilateral lower extremities. The patient is diagnosed with degenerative disk disease with lumbar radiculopathy, facet arthropathy of the lumbar region, and sprain/strain of the lumbar region.

IMR ISSUES, DECISIONS AND RATIONALES

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

METHADONE 10MG HCL TABLETS #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 75-94.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommend chronic opioid therapy when certain criteria have been met, including adequate analgesia, no adverse effects, no aberrant behavior, and improvement in activities of daily living. The clinical documents provided do not provide sufficient evidence that the patient has received significant improvement in analgesia or increased activities of daily living. The indication for the opioid therapy is not clear from the documents provided. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

MELOXICAM 15MG #30 WITH 2 REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommend NSAID therapy at the lowest dose for the shortest period of time for moderate to severe pain. The guidelines state there is no evidence of long-term effectiveness for pain or function. The documents provided did not provide adequate rationale for the medication. The documents did not clearly show the medication provided sufficiently improved analgesia. The duration of therapy is not clear from the documents, but chronic use is not recommended. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.