

Case Number:	CM14-0019382		
Date Assigned:	04/21/2014	Date of Injury:	09/19/1988
Decision Date:	07/02/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	02/14/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California and Nevada. 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 54 year old male injured on 09/19/88 due to an undisclosed mechanism of injury. Current diagnoses include lumbar degenerative disc disease, lumbar radiculitis, status post multiple lumbar spine fusion surgeries, failed back surgery syndrome, lumbar myofascial pain syndrome, and status post abdominal hernia repair. The clinical documentation indicates the injured worker recently suffered a comminuted right intertrochanteric hip fracture requiring Open Reduction Internal Fixation (ORIF) of the right hip on 04/21/14 related to a recent fall unrelated to the previous injury. Previous treatments included medication management, pool therapy, home exercise program, and massage therapy. Previous utilization review listed medications as Methadone 10mg 2-3 tablets eight hours daily, Valium 10mg, Oxycontin 10mg, and Oxy IR 15mg totaling greater than the 1,000 morphine equivalent dosage (MED). The clinical noted dated 12/27/14 indicated the injured worker was treated for chronic low back pain described as left sided body pain rated at 5/10. Physical assessment revealed limited range of motion of the lumbar spine and negative orthopedic testing for sciatic nerve tension. The documentation indicated an intent to refill medication. The request for Methadone 10mg #240 and Valium 10mg #60 was initially non-certified on 01/16/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

METHADONE 10MG #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, injured workers must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. The documentation indicates the injured worker's morphine equivalent dosage (MED) greatly exceeds the recommended 120mg/day. Additionally, there is no subsequent post-operative documentation to establish the injured worker's clinical status and medication needs. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Methadone 10MG #240 cannot be established at this time.

VALIUM 10MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 24.

Decision rationale: As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to four weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The patient has exceeded the four week treatment window. As such, the request for Valium 10mg #60 cannot be recommended at this time.