

Case Number:	CM14-0115429		
Date Assigned:	08/04/2014	Date of Injury:	01/12/2009
Decision Date:	09/16/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	07/23/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in 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 records presented for review indicate that this 60 year-old individual was reportedly injured on 1/12/2009. The mechanism of injury is not listed. The most recent progress note, dated 6/20/2014. Indicates that there are ongoing complaints of low back pain that radiates in the right lower extremity. The physical examination demonstrated lumbar spine: positive tight left lumbar paraspinals with palpation. Limited range of motion. Right knee: positive swelling, positive tenderness to palpation medial/lateral joint line, and popliteal space. Limited range of motion. Positive Lachman, positive McMurray, positive patellar grind test. Right hip: positive tenderness to palpation trochanteric bursa, Limited range of motion with pain. Positive Thomas Test, Positive Faber Test. Diffuse weakness right lower extremity muscle testing. Reduce sensation to light touch bilateral foot in stocking distribution. Antalgic gait. No recent diagnostic studies are available for review. Previous treatment includes medications, and conservative treatment. A request had been made for Methadone 10 mg #135 and was not certified in the pre-authorization process on 7/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective Request for Methadone 10Mg #135: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61-62.

Decision rationale: As noted in the MTUS, this medication is recommended as a 2nd line drug for moderate to severe pain. The utilization of medication is only if the benefit outweighs the risk. It is noted that there is a severe morbidity and mortality associated with the use of this medication. This medication is used with caution and those people with decreased respiratory reserve (asthma, COPD, sleep apnea, severe obesity). Further, there are a number of basic rules that must be met when prescribing this medication, as outlined in the MTUS. After review the medical documentation provided there was no objective or subjective clinical findings stating the reduction in pain and increase in function due to the use of this medication. Therefore, the ongoing use of this medication is not determined to be medically necessary.