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| Case Number: | CM14-0116069 | | |
| Date Assigned: | 08/04/2014 | Date of Injury: | 08/13/2008 |
| Decision Date: | 09/10/2014 | UR Denial Date: | 07/15/2014 |
| Priority: | Standard | Application Received: | 07/24/2014 |

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 Texas and Oklahoma. 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 55-year-old male who reported injury on 08/13/2008. The mechanism of injury was a fall. The injured worker had left shoulder surgery in 2010 and 2012. Prior therapies included physical therapy and medication management. The diagnostic studies were not provided. The documentation of 07/03/2014 reveals the injured worker's current medications included Benicar 40 mg tablets, Celebrex 200 mg capsules and methadone 10 mg tablets. The injured worker indicated his pain was the same as a previous visit. The injured worker indicated that the pain level was 7/10. The injured worker indicated his pain medications cover about 71% to 80% of the discomfort. The physical examination revealed the knee reflexes, ankle reflexes, triceps reflexes and biceps reflexes were 1+, as well as the brachioradialis. The diagnoses included sprain and strain of the shoulder and upper arm rotator cuff. The treatment plan included methadone 10 mg 3 tablets 4 times a day for chronic pain. There was no DWC form RFA submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Three Hundred Sixty (360) Tablets of Methadone 10 mg.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60; 78; 86.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain and evidence the injured worker is being monitored for aberrant drug behavior and side effects. The cumulative dosing should not exceed 120 mg of oral morphine equivalents per day. The clinical documentation submitted for review indicated the injured worker was to take methadone 10 mg 3 tablets 4 times a day, which would exceed the guideline recommendations of 120 daily morphine equivalent dose. The daily morphine equivalent dose would be 1,440. The duration of use could not be established through supplied documentation. There was a lack of documentation indicating a necessity for 360 tablets of methadone 10 mg, if the injured worker took the medication as prescribed, 120 tablets would be a month's supply. There was a lack of documentation of exception factors to warrant nonadherence to guideline recommendations. Additionally, the request, as submitted, failed to indicate the frequency for the requested medication. Given the above, the request for 360 tablets of methadone 10 mg is not medically necessary.