

Case Number:	CM14-0045343		
Date Assigned:	07/02/2014	Date of Injury:	08/25/2010
Decision Date:	08/21/2014	UR Denial Date:	03/06/2014
Priority:	Standard	Application Received:	04/01/2014

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 and 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 64 year old male was reportedly injured on 8/25/2010. The mechanism of injury is undisclosed. The most recent progress note, dated 1/9/2014, indicated that there were ongoing complaints of right shoulder and right knee pains. The physical examination demonstrated right shoulder limited range of motion without pain, strength 4+/5 with flexion abduction, external rotation 3-/5 and internal rotation 5/5. Left knee had range of motion 0-120 degrees without pain. No laxity/instability noted and neurovascular intact. Right knee had soft tissue swelling, positive tenderness and gravitation with range of motion, which is 0-120 degrees, 1 + varus/valgus laxity as well as anterior drawer and 1 + Lachman trace pivot shifts. Diagnostic imaging studies included x-rays of the right knee, which revealed moderate patellofemoral osteoarthritis and moderate medial/lateral compartment osteoarthritis. Previous treatment included previous surgery, physical therapy, medications, and conservative treatment. A request was made for methadone 10mg, #120 and was not certified in the pre-authorization process on 3/6/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone HCL 10mg, #120: Upheld

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

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

Decision rationale: Methadone is recommended as a second line drug for moderate to severe pain, only if the potential benefit outweighs the risk, unless methadone is prescribed by pain specialists with experience in its use and by addiction specialists, where first line use may be appropriate. Due to the complexity of dosing and potential for adverse effects including respiratory depression and adverse cardiac events, this drug should be reserved for use by experienced practitioners. After review of the medical records provided, there was no determination of documented failure of a first line pain medication. Therefore, this request is deemed not medically necessary.