

<b>Case Number:</b>	CM14-0188400		
<b>Date Assigned:</b>	11/19/2014	<b>Date of Injury:</b>	05/24/2010
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 55 year old male employee with date of injury of 5/24/2010. A review of the medical records indicates that the patient is undergoing treatment for lumbar degenerative disc disease; intermittent claudication and leg cramps, right leg; neuropathic burning pain, right leg; insomnia due to pain and reactive depression. Subjective complaints include severe back pain flare ups shooting down left leg (and claims that current pain medications are not sufficient). Objective findings include physical exam revealing antalgic posture and forward-flexed lower back, palpation reveals lumbar paraspinal muscle spasm. Right and left SLRs are 80; alerted sensory loss at right lateral calf and bottom of foot. 4/5 weakness in right thigh flexion, knee extension and big toe extension. Absent right Achilles reflex, +1 on left and +1 at bilateral knees. Treatment has included PT, TENS unit, ice packs, epidural steroid injections and intramuscular injections. Medications have included Methadone, Oxycodone, Flexeril, and Valium. The utilization review dated 10/24/2014 non-certified the request for Methadone 10 mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methadone 10 mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Methadone Page(s): 74-96.

**Decision rationale:** MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include the following: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. In addition, the patient has been on methadone in excess of guideline recommendation without significant functional improvement. As such, the request for Methadone 10 mg, #90 is not medically necessary.