

<b>Case Number:</b>	CM15-0109944		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	10/09/2009
<b>Decision Date:</b>	07/17/2015	<b>UR Denial Date:</b>	05/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 37 year old male with an industrial injury dated 10/09/2009. The injured worker's diagnoses include degeneration of lumbar/lumbosacral intervertebral disc, spinal stenosis of the lumbar region without neurogenic claudication, lumbago, thoracic or lumbosacral neuritis or radiculitis, and muscle spasm. Treatment consisted of prescribed medications, physical therapy and periodic follow up visits. In a progress note dated 05/12/2015, the injured worker reported low back pain rated a 7/10. Objective findings revealed limited lumbar flexion due to moderate low back pain, facet tenderness to palpitation of the lumbar facets, bilateral positive straight leg raises, spasm and twitching with point tenderness and decrease sensation in the bilateral lower extremities. The treatment plan consisted of medication management. The treating physician prescribed Methadone 10mg #90 now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methadone 10mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for Methadone, California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Methadone is not medically necessary.