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| Case Number: | CM15-0219753 | | |
| Date Assigned: | 11/12/2015 | Date of Injury: | 09/16/1996 |
| Decision Date: | 12/23/2015 | UR Denial Date: | 10/19/2015 |
| Priority: | Standard | Application Received: | 11/09/2015 |

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: Preventive Medicine, Occupational Medicine

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 56 year old male who sustained an industrial injury on 09-16-1996. Medical records indicated the worker was treated for chronic neck and upper back pain. In the provider notes of 10-07-2015, the injured worker complains of body aches and persistent and constant upper body pain. Pain was rated a 6 on a scale of 10 at its worst and a 5 on a scale of 10 with medications. The worker complains of constant insomnia, which is receiving treatment under psych, and has foot pain that is being treated by a podiatrist. On exam, the worker has decreased cervical rotation bilaterally, bilateral facet loading and tenderness to palpation of the cervical spine. Myofascial spasms are present in the upper and mid back. He is encouraged to exercise, and continue medication regimens, continue care with podiatrist, and continue care with psychiatrist. A request for authorization was submitted for Methadone 10 mg Qty 90. A utilization review decision 10-19-2015 modified the request to certify 1 prescription of Methadone 10 mg #33 between 10-07-2015 and 12-15-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 10 mg Qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Methadone, Opioids (Classification), Opioids, criteria for use, Opioids, dosing, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures, Opioids, criteria for use, Opioids, dosing.

Decision rationale: MTUS Guidelines have very specific criteria to justify the long-term use of opioid medications for non-cancer pain. A major criteria is a well documented improvement in function due to opioid use. The Guideline standards include objective measures and specific detailing of functional improvements associated with use. There is inadequate documentation of functional improvements due to Methadone use and due to the high dosing (240mg Morphine Equivalent Dose) this Guideline standard is to be followed closely. There are no unusual circumstances to justify an exception to Guidelines. The Methadone 10 mg Qty 90 is not medically necessary.