

Case Number:	CM15-0044684		
Date Assigned:	03/17/2015	Date of Injury:	11/09/2009
Decision Date:	06/01/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	03/10/2015

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: Texas, Illinois

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 31 year old male, who sustained an industrial injury on 11/09/2009. Diagnoses include chronic low back pain, lumbar facetar arthritis, right sacroiliitis, possibility of lumbar radiculopathy and myofascial pain. Treatment to date has included diagnostics including magnetic resonance imaging (MRI), medications, home exercise and an H wave unit trial. Per the Primary Treating Physician's Progress Report dated 1/28/2015, the injured worker reported persistent low back pain rated as 7/10 with radiation to the right lower extremity and numbness in the left leg. Physical examination revealed an antalgic gait on the right with tenderness noted in the lumbar facet joints. The plan of care included medications and authorization was requested on 2/05/2015 for Methadone 10 mg, Methadone 5mg, Gralise 600mg, Omeprazole 20mg and extension on H wave unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 10mg #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic pain, Opioids/medication.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 78-81.

Decision rationale: The injured worker sustained a work related injury on 11/09/2009. The medical records provided indicate the diagnosis of chronic low back pain, lumbar facetar arthritis, right sacroiliitis, possibility of lumbar radiculopathy and myofascial pain. Treatments have included home exercises, H-Wave unit. The medical records provided for review do not indicate a medical necessity for Methadone 10mg #90 with 3 refills. The MTUS recommends the use of the lowest dose of opioids for the short-term treatment of moderate to severe pain. The MTUS does not recommend the use of opioids for longer than 70 days in the treatment of chronic pain due to worsening adverse effects and lack of research in support of benefit. Also, the MTUS recommends that individuals on opioid maintenance treatment be monitored for analgesia (pain control), activities of daily living, adverse effects and aberrant behavior; the MTUS recommends discontinuation of opioid treatment if there is no documented evidence of overall improvement or if there is evidence of illegal activity or drug abuse or adverse effect with the opioid medication. The records indicate the injured worker's use of this medication predates 06/2014, but with no overall improvement; there is no proper monitoring of pain relief, or activities of daily living. The request is not medically necessary.