

Case Number:	CM14-0016218		
Date Assigned:	04/14/2014	Date of Injury:	12/10/2002
Decision Date:	05/28/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/10/2014

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 Occupational Medicine and is licensed to practice in California. 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 patient is an employee of [REDACTED] and has submitted a claim for lumbar disc protrusion associated with an industrial injury date of 12/10/2002. Treatment to date has included global fusion L4-5, L5-S1 on 07/17/2009 and subsequent hardware removal, and medications such as Cymbalta, methadone, Neurontin, Norco, Nuvigil, Linzess, Prilosec, and Wellbutrin. Utilization review from 01/21/2014 denied the request for ECG because there was no given rationale and no coronary artery disease risk factors were present. The same review modified the request for Methadone 10mg, Qty 120 into Methadone 10mg, Qty 60 to initiate a weaning process and because there was no documentation of symptomatic relief or functional improvement from its use. Medical records from 2013 to 2014 showed that the patient complained of low back pain graded 7/10 in severity described as aching, burning, cramping, and stabbing associated with stiffness. He also complained of numbness and weakness in both legs. Rest alleviated pain. Patient experienced increasingly severe upper extremity and lower extremity neuropathic dysesthesia over the past few months. A sleep study did not show sleep apnea, but did show somnolence. Patient reported that medications provided relief of symptoms and resulted to 60% improvement in his global functional capacity. No fatigue resulted from intake of medications. There was likewise no signs of illicit drug abuse or diversion. Physical examination showed tenderness over the L4 to S1 spinous processes bilaterally with triggering, ropey fibrotic banding and muscle spasm. Muscle strength was 4/5 for right hip flexors; 3/5 for right foot dorsiflexor and plantarflexor; 5-/5 for bilateral hip external rotator, internal rotator, gluteal, foot dorsiflexor, and plantarflexor. Straight-leg raise testing was positive at left side at 70 degrees with pain radiating to the left gluteal, posterior hip, medial leg; and positive at right side at 70 degrees with pain radiating to right gluteal, posterior thigh, medial and lateral leg, posterior calf and heel. Sensation was decreased to light touch at L4 dermatome, left. Gait was antalgic.

IMR ISSUES, DECISIONS AND RATIONALES

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

METHADONE 10MG, QTY 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61-62, 67.

Decision rationale: Page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. The California MTUS on pages 61-62 also indicate that methadone is recommended as a second line drug for moderate to severe pain if the potential benefit outweighs the risk. In this case, the earliest progress report available citing the prescription for methadone is dated May 2013. The 1/8/14 records indicate that it provided symptom relief and resulted to 60% improvement in his global functional capacity. There was no noted side effects such as fatigue. There was likewise no signs of illicit drug abuse or diversion from its use as stated. The most recent urine drug screen is dated 04/07/2014 showing presence of methadone. However, It is not clear why he was placed on methadone since it is only recommended as a second line drug recommended for patients who have developed tolerance to other opioids or where there have been intolerable side effects from other opioids. The patient is also on Norco, and there is no documentation concerning failure of other stronger opioids such as Oxycodone or Fentanyl. The medical necessity for this medication has not been established. Therefore, the request for Methadone 10mg, qty 120 is not medically necessary.

ELECTROCARDIOGRAM (ECG): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Harrison's Principles of Internal Medicine, 18th Edition., Chapter 228 Electrocardiography.

Decision rationale: CA MTUS does not specifically address this issue. As stated in Harrison's Principles of Internal Medicine, Electrocardiogram (ECG) is used in detecting arrhythmia, conduction abnormalities, myocardial ischemia, metabolic disturbances or increased susceptibility to sudden cardiac death (QT prolongation syndrome). In this case, even if the patient is on methadone and has increased risk for QT prolongation, there is no evidence on such based on the medical records submitted. However, in the review of systems section, there was noted positive for chest pain. Yet, chest pain was already documented as far back as progress reports dated May 2013. There are no new subjective complaints that will necessitate a sudden

request for an ECG. Furthermore, the cardiovascular exam showed unremarkable findings. There is no provided rationale for requesting ECG at present. Additionally, it has been determined that Methadone is not medically necessary. Therefore, the request for ECG is not medically necessary.