Case Number:	CM14-0129050		
Date Assigned:	08/18/2014	**Date of Injury:**	07/22/2003
Decision Date:	09/12/2014	**UR Denial Date:**	07/30/2014
Priority:	Standard	**Application Received:**	08/13/2014

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 Internal Medicine, has a subspecialty in Hospice and Palliative Medicine and is licensed to practice in Pennsylvania. 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 injured worker is a 56-year-old gentleman with a date of injury of 07/22/2003. The submitted and reviewed documentation did not identify the mechanism of injury. Office visit notes by [redacted] dated 03/17/2014 and 04/14/2014 indicated the worker was taking a stable dose the pain medication Suboxone (buprenorphine with naloxone). More recent records were not submitted. Examinations consistently described lumbar tenderness and decreased joint motion. The submitted documentation concluded the worker suffered from myelopathy, pain after back surgery, right lumbar radiculitis, left cervical radiculopathy, depressive disorder, sleep problems, decreased sexual desire, high blood pressure, a skin cancer, and a skin-picking condition. Recommended treatment included continuing the worker's blood pressure medication, continuing the pain medication, continuing medication for high cholesterol, checking laboratory studies, and checking the QT interval before starting unreported psychiatric medication(s) requested by a psychiatrist. The psychiatrist's report was not submitted. A Utilization Review decision by [redacted] was rendered on 07/30/2014 recommending non-certification for Suboxone (buprenorphine with naloxone) 8mg, #90 and electrocardiography.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective usage of Suboxone 8mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids,Buprenorphine Page(s): 74-95,26-27.

Decision rationale: Suboxone contains two medications, buprenorphine and naloxone. Buprenorphine is a unique opioid (a partial agonist at the mu receptor) used for pain control that also acts as an antagonist at the kappa receptor. Naloxone is an opioid antagonist, an "anti-opioid." The MTUS Guidelines stress the lowest possible dose of opioid medications should be prescribed to improve pain and function, and monitoring of outcomes over time should affect treatment decisions. Documentation of pain assessments should include such elements as the current pain intensity and the pain intensity after taking the opioid medication, among others. Acceptable results include improved function, decreased pain, and/or improved quality of life. The MTUS Guidelines recommend opioids be continued when the worker has returned to work and if the worker has improved function and pain control. However, an ongoing review of the overall situation should be continued with special attention paid to the continued need for this medication, potential abuse or misuse of the medication, and non-opioid methods for pain management. The submitted and reviewed documentation indicated the worker was treated with an unchanging dose of Suboxone for an unreported length of time. The pain location, intensity, character, modulation, and associated symptoms were not reported. The benefits, side effects, and worker's function related to Suboxone were not described. There was no discussion why naloxone was included in the worker's treatment plan. While the MTUS Guidelines recommend a generally slow but individualized taper of opioid medications when they are no longer shown to be helpful, buprenorphine causes a much milder withdrawal syndrome that other opioid medication. The submitted and reviewed documentation did not support a continued benefit from buprenorphine. In the absence of such evidence, the current request for Suboxone (buprenorphine with naloxone) 8mg, #90 is not medically necessary.

Electrocardiography (ECG): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Bonow: Braunwald's heart disease-A text book of cardiovascular medicine, 9th ed. Chapter 13.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Berul CI, et al. Acquired long QT syndrome. Topic 1043, version 16.0. UpToDate, accessed 09/09/2014.

Decision rationale: The MTUS Guidelines are silent on this issue in this clinical situation. Electrocardiography (ECG) looks at the flow of electricity through the heart and creates a tracing or image that reflects this flow. This flow of electricity is related to heart rhythm and rate. A long QT interval, or prolonged QT syndrome, is an abnormal heart rhythm that can be seen with ECG but not with physical examination. There are many medications that can increase the QT interval, including some psychiatric medications, heart medications, and allergy medications. The submitted and reviewed documentation indicated a psychiatrist had recently recommended medications that may increase the QT interval. However, the date and results of the worker's

most recent ECG, the medications recommended, the planned initiation of the therapy, and the individualized risk to the patient were not discussed. In the absence of such evidence, the current request for electrocardiography (ECG) is not medically necessary.