MAXIMUS Federal Services

Case Number:	CM15-0003363		
Date Assigned:	01/14/2015	Date of Injury:	04/28/2000
Decision Date:	03/10/2015	UR Denial Date:	12/15/2014
Priority:	Standard	Application Received:	01/07/2015

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: Ohio, North Carolina, Virginia
Certification(s)/Specialty: Family Practice

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 50 year old male, who sustained an industrial injury on 4/28/2000. He fell backwards on a construction site and was impaled on a stake that was driven into the ground. It went through his rectal area and tore his bladder wall. The diagnoses have included back pain, degenerative disc disease, myofascial pain, lumbar degenerative disc disease, sciatica, low back pain, arthritis of the back and leg cramps. Treatment to date has included surgical intervention and medications. After the surgery he reported a significant amount of back pain. Currently, the IW complains of aching, shooting, back pain and right leg pain. He reports a flare up of lower back pain with radiation down the back of his right leg. Objective findings include lumbar spine bilateral tenderness and pain with diminished range of motion. Straight leg raise test is negative. On 12/15/2014 Utilization Review non-certified an electrocardiogram (EKG) and modified a prescription for Methadone 5mg #120, noting that the lack of medical necessity. Non- MTUS Guidelines were cited. On 1/07/2015, the injured worker submitted an application for IMR for review of an electrocardiogram (EKG) and modified a prescription for Methadone 5mg #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 EKG between 12/4/2014 and 2/7/2015: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The National Guideline Clearinghouse (NGC)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain (Chronic)

Decision rationale: Patients should be informed of arrhythmia risk when prescribed methadone. An assessment should be made of history of structural heart disease, arrhythmia, and syncope. No firm guides are agreed upon in terms of pre-treatment or interval EKGs, but recommendation for use is particularly made for patients on high dose drug with cardiac history or evidence of syncope or seizures. In this instance, the utilization review physician stated that an EKG was certified on 7-28-2014 and therefore another should not be necessary. However, the cited guidelines can certainly be interpreted to mean that the interval for EKG screening for patients receiving methadone is largely a judgement call by the treating physician. Therefore, because 6 months has elapsed since the last EKG, 1 EKG between 12/4/2014 and 2/7/2015 is medically necessary.

Unknown prescription of Methadone 5mg, #120: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Patients prescribed opioids chronically require ongoing assessment of pain relief, functionality, medication side effects, and any aberrant drug taking behavior. Opioids may generally be continued if there is improvement in pain and functionality as a consequence of the medication. In this instance, the only treatment note provided dates from 7-17-2014 at which time the injured worker was prescribed methadone 5 mg, #75 in a month. The request in this instance is for #120 in a month. On 7-17-2014 it was stated that the injured worker had 60-70% pain and functional improvement on the pain medication. It is presumed that the methadone has been adjusted upwards to meet the pain needs presented. The treating physician documents urine drug screening and pharmacy data base monitoring. Therefore, Methadone 5mg, #120 is medically necessary.