

<b>Case Number:</b>	CM13-0031268		
<b>Date Assigned:</b>	12/04/2013	<b>Date of Injury:</b>	05/23/1988
<b>Decision Date:</b>	02/14/2014	<b>UR Denial Date:</b>	09/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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:

He is a 72-year-old male with date of injury 05/23/1988. Records were available for review dating back to March of 2005, although many were handwritten and eligible. It is clear from the records that the patient has had a serious problem with opiate addiction. Sometime prior to March of 2005 he was started on Suboxone in lieu of other narcotic medications. The patient was under the care of [REDACTED] from 2005 until August or September of 2012 when he was forced to change her primary treating physicians. The patient had been taking up to 30 mg daily of Suboxone throughout that time. In October of 2012 he came under the care of the physicians at the [REDACTED]. At least two attempts were made by those physicians to taper the patient Suboxone. Each attempt failed apparently. According to the medical records the patient became angry with his treatment in September of 2013 and the doctor/patient relationship was severed by [REDACTED], the medical director of [REDACTED]. His care was then picked up by [REDACTED] who was attempting to treat the patient's addiction to narcotics. [REDACTED] diagnoses at this time are, 1. Chronic spinal pain likely associated with disc injury, and 2. Pseudo-addiction. The patient is currently taking trazodone 100 mg q.h.s. for sleep and his Suboxone dose is 8-2 mg 3 times per day.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pharmacy purchase of Suboxone 8.2mg #60:** Overturned

**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 Page(s): 26-27.

**Decision rationale:** The previous utilization review physician did not have the benefit of the entire medical record which I have had opportunity to review; consequently, it would have been impossible for the reviewer to know that the patient receives Suboxone as maintenance therapy for his previous serious addiction, chronic pain, and sleep disorder. The MTUS does recommend Suboxone for the treatment of opiate addiction and for chronic pain. See the following: Suboxone is recommended for treatment of opiate addiction. Also recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction (see below for specific recommendations). A schedule-III controlled substance, buprenorphine is a partial agonist at the mu-receptor (the classic morphine receptor) and an antagonist at the receptor (the receptor that is thought to produce alterations in the perception of pain, including emotional response). In recent years, Buprenorphine has been introduced in most European countries as a transdermal formulation ("patch") for the treatment of chronic pain. Proposed advantages in terms of pain control include the following: (1) No analgesic ceiling; (2) A good safety profile (especially in regard to respiratory depression); (3) Decreased abuse potential; (4) Ability to suppress opioid withdrawal; & (5) An apparent antihyperalgesic effect (partially due to the effect at the kappa-receptor). (Kress, 2008) (Heit, 2008) (Johnson, 2005) (Landau, 2007) Available formulations: Buprenorphine hydrochloride: Buprenex®: Supplied as an injection solution; Subutex®: Supplied as a sublingual tablet in 2 daily dosage strengths (2 mg or 8 mg). Indications: Treatment of opiate agonist dependence (FDA Approved indication includes sublingual Subutex® and Suboxone®): Recommended. When used for treatment of opiate dependence, clinicians must be in compliance with the Drug Addiction Treatment Act of 2000. (SAMHSA, 2008) Buprenorphine's pharmacological and safety profile makes it an attractive treatment for patients addicted to opioids. Buprenorphine's usefulness stems from its unique pharmacological and safety profile, which encourages treatment adherence and reduces the possibilities for both abuse and overdose. Studies have shown that Buprenorphine is more effective than placebo and is equally as effective as moderate doses of methadone in opioid maintenance therapy. Few studies have been reported on the efficacy of Buprenorphine for completely withdrawing patients from opioids. In general, the results of studies of medically assisted withdrawal using opioids (e.g., methadone) have shown poor outcomes. Buprenorphine, however, is known to cause a milder withdrawal syndrome compared to methadone and for this reason may be the better choice if opioid withdrawal therapy is elected. (McNicholas, 2004) (Helm, 2008). For the reasons described above the request is medically necessary and appropriate in this case.