

Case Number:	CM14-0131244		
Date Assigned:	09/10/2014	Date of Injury:	01/13/2006
Decision Date:	10/06/2014	UR Denial Date:	07/26/2014
Priority:	Standard	Application Received:	08/15/2014

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:

According to the provided medical records, this is a 57-year-old man injured on 1/13/6. He has had back surgery, spinal cord stimulator recently revised. There is a 1/8/14 pain management report that indicates this patient had complaints of low back pain, bilateral leg pain, intermittent rib stimulation from spinal cord stimulator and no stimulation felt on the left side for the spinal cord stimulator. There was discussion that the patient saw a different Dr. who recommended medication detoxification options that include slow detox off Percocet as an outpatient, converting to a different analgesic including buprenorphine and possibly Lyrica. The treatment plan indicated that the patient was going to have the spinal cord stimulator lead revised, he would be converted to Lyrica from gabapentin and after that occurred there would be consideration for conversion to buprenorphine from oxycodone. 5/6/14 report indicates patient was having increased back pain and because of that it was not felt that he would tolerate an outpatient taper of the Percocet (dose 10-325 on 4 times a day), noted that the patient was requiring increased opiate amounts and at the Lyrica did not help. Patient was resumed on gabapentin. At that point he had been switched to buprenorphine and was off of the oxycodone, he was taking 40 mg per day on bad days and on good days he was taking 20 mg a day. The report and states he was taking 8 mg and 2 mg tabs 2-4 times a day and getting minimal pain relief with the buprenorphine. He had been more sleepy. The treatment plan states the patient was to continue buprenorphine up to 40 mg per day as needed and to start tramadol for better pain control with the goal to decrease buprenorphine to 24 mg per day. Effexor was to be restarted. The spinal cord stimulator lead revision took place on 5/15/14. Follow up with pain management 5/23/14 indicated that the neurostimulator at that point was providing good coverage to the low back and legs. He need an increase in opiates from the post incisional pain. Patient was given Norco for 2 weeks and he was then to stop it. 6/30/14 report did mention

discontinuing the Norco but also state that the patient was to continue buprenorphine up to 32 mg a day and continue on the tramadol with the goal of decreasing buprenorphine used to 24 mg per day. 7/2/14 pain management report included subjective complaints that the patient's pain was better managed on the current regimen, he was off Norco and needed a refill of buprenorphine. He is doing better on the Effexor. Urine medication screen was ordered that date. Patient was to continue buprenorphine up to 32 mg per day as needed. Continue tramadol for better pain control with the goal to decrease Buprenorphine used to 24 mg per day. Pain is better managed since the revision of the SCS. Patient was given tramadol 50 mg #180 with 2 refills and buprenorphine 8 mg to use 4 times a day #120. Diagnoses were lumbar or lumbosacral disc degeneration; Postlaminectomy syndrome of lumbar region; thoracic or lumbosacral neuritis or radiculitis not otherwise specified, encounter for long-term use of other medications and sleep disturbance not otherwise specified. None of the medical reports document the actual daily frequency of use of either the tramadol or the buprenorphine, the patient's routinely given the same quantities each month so presumably he is taking all of them. This is 60 morphine equivalent dose per day from tramadol. Previously, the patient used Percocet, which contains oxycodone 10 mg 4 times a day which is also 60 morphine equivalent doses per day. The records indicate that the tramadol had to be added because the pain control from the buprenorphine was insufficient. Progress notes repeatedly state that the goal is to reduce the buprenorphine with the addition of the tramadol but there had not taken place. There was no mention of a plan to formally taper the buprenorphine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Buprenorphine 8mg, qty 120: 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 Buprenorphine; opiates Page(s): 26-27; 74,79. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) morphine equivalent dose calculator

Decision rationale: MTUS guidelines recommend this for treatment of opiate addiction and also recommend this as an option for chronic pain especially after detoxification in patients who have a history of opiate addiction. In this case, the patient was using Percocet with a morphine equivalent daily dose of 60, less than MTUS guidelines recommended daily maximum of 120. He had a spinal cord stimulator but one lead was not working. The plan was to switch the patient to buprenorphine in order to stop the use of the Percocet. This was done successfully, but not without the addition of another opiate, tramadol at the same dosing level of 60 morphine equivalents per day. In the meantime, the patient had a spinal cord stimulator lead placement revised with reported good results. So the end result was that now the patient is taking 2 opiate medications (tramadol and buprenorphine), and he is still on the same morphine equivalent dose. The buprenorphine failed to result in any reduction in the daily dose of morphine equivalents and there is no documentation that it has resulted in any improved functional benefit or reduction in dependence on medical treatment. MTUS guidelines state that opiates should be discontinued if

there is no overall improvement in function. Therefore based upon the evidence and the guidelines, this is not approved.