

<b>Case Number:</b>	CM14-0163582		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	05/04/2006
<b>Decision Date:</b>	11/28/2014	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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 Family Medicine and is licensed to practice in Ohio. 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 59 year old male with several dates of injury, the most recent being 5-04-2006. His diagnoses include chronic neck and back pain, cervical and lumbar radiculopathy, lumbar spondylolisthesis, and cervical degenerative disc disease. He had anterior discectomies with disc replacement at C4-C5, C5-C6, and C6-C7 on 3-16-2010. In 2011 he underwent lumbar fusion from L3 to S1. Post-operative, he was doing well from both surgeries. He had increased his functionality, having returned to school to get his teaching credentials, and he was taking an anti-inflammatory and Ultram 4 times a day for pain. In December of 2013, things began to worsen in terms of pain and numbness in the lower extremities. His neurologic exam had worsened by July 2014, showing diminished lower extremity reflexes. The pain medication was increased and Norco was restarted. A CT scan of the lumbar spine revealed collapse of L2-L3 just above his fusion. Butrans mcg/hour patches were started on 8-21-2014 and the Norco was maintained at 7.5/325 mg every 12 hours as needed for breakthrough pain. The physical exam reveals diminished cervical range of motion and tenderness to palpation from C4-C6. Upper extremity strength, reflexes and sensation are intact. A number of consistent urine drug screens are on file.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Butrans patch 5mcg # 4 with six refills:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain, Buprenorphine

**Decision rationale:** The Official Disability Guidelines recommended buprenorphine as an option for treatment of chronic pain (consensus based) in selected patients (not first-line for all patients). Suggested populations: (1) Patients with a hyperalgesic component to pain; (2) Patients with centrally mediated pain; (3) Patients with neuropathic pain; (4) Patients at high-risk of non-adherence with standard opioid maintenance; (5) For analgesia in patients who have previously been detoxified from other high-dose opioids. Use for pain with formulations other than Butrans is off-label. Due to complexity of induction and treatment the drug should be reserved for use by clinicians with experience. For those requiring opioids for chronic pain, there should be ongoing monitoring of pain relief, functionality, adverse reactions, and any aberrant drug taking behavior. Opioids may be continued when there is demonstrable increase in functioning. In this instance, an extended release pain formulation appears appropriate given the chronicity of the pain. Appropriate monitoring appears to be occurring. The injured worker appears to be deriving functional benefit from the opioids. Therefore, Butrans patch 5mcg # 4 with six refills is medically necessary.

**Norco 7.5/325mg, #60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Norco, Weaning of Medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Buprenorphine Page(s): 26-2, 74-96.

**Decision rationale:** For those requiring opioids for chronic pain, there should be ongoing monitoring of pain relief, functionality, adverse reactions, and any aberrant drug taking behavior. Opioids may be continued when there is demonstrable increase in functioning. Buprenorphine is recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction. A schedule-III controlled substance, buprenorphine is a partial agonist at the mu-receptor (the classic morphine receptor) and an antagonist at the kappa 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). Buprenorphine is a rather complex medication for pain or addiction in that, as a partial opioid agonist, it may tend to displace other opioids that may be used for breakthrough pain, for example hydrocodone (Norco). The combination of buprenorphine and other opioids should be prescribed by those with experience doing so. Traditional scales for

opioid rotation and for weaning from drug X and starting drug Y are not applicable because of this tendency for buprenorphine to displace other opioids. Therefore, Norco 7.5/325mg #60 is medically necessary in this circumstance.