

<b>Case Number:</b>	CM14-0179180		
<b>Date Assigned:</b>	11/03/2014	<b>Date of Injury:</b>	09/12/2008
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/28/2014

### 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:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic neck and shoulder pain reportedly associated with an industrial injury of September 12, 2008. Thus far, the applicant has been treated with the following: Analgesic medications; long and short-acting opioids; transfer of care to and from various providers in various specialties; unspecified amounts of physical therapy over the course of the claim; and extensive periods of time off of work. In two separate Utilization Review Reports dated October 24, 2014, the claims administrator failed to approve request for clonidine, phenobarbital, Suboxone, morphine extended release, and morphine immediate release. The applicant's attorney subsequently appealed. In an April 18, 2014 progress note, the applicant reported 6/10 neck and shoulder pain with associated sleep disturbance. The applicant stated that his medications were less effective over time. The applicant was attending a functional restoration program, it was noted. The applicant's medication list included Colace, Flonase, Lidoderm, Zestoretic, Lopressor, Robaxin, Mevacor, OxyContin, Prilosec, and Zantac, it was noted. It was not clear whether the medication list was up to date. The applicant was asked to continue MS Contin in another section of the note. The applicant was placed off of work, on total temporary disability. On May 13, 2014, the applicant again reported 6/10 neck and shoulder pain. The applicant was again placed off of work, on total temporary disability. The applicant stated that his quality of sleep was poor. The attending provider then stated, somewhat incongruously, that the applicant's pain complaints were well managed with medications. The applicant was reportedly using Flonase, Colace, Lidoderm, Zestoretic, Lopressor, Robaxin, Mevacor, Prilosec, morphine, Zantac, and Valium, it was stated in one section of the note. The applicant was given prescriptions for MS Contin and immediate release morphine in another section of the note. The applicant reportedly completed a functional restoration program but was again placed off of

work, on total temporary disability. On June 18, 2014, the attending provider has suggested that the applicant was having persistent complaints of shoulder and neck pain. The applicant was having side effects such as loss of energy. The applicant had apparently developed nausea and vomiting for an unknown reason. The applicant was asked to consider an inpatient detoxification program. Valium, Colace, morphine, and extended release morphine were endorsed while the applicant was kept off of work. On October 23, 2014, the applicant reported 9/10 neck and shoulder pain. The applicant acknowledged that the medications in question were not effective. The applicant's medication list included Colace, Flonase, Lidoderm, Zestoretic, Lopressor, Mevacor, Robaxin, Valium, Protonix, Catapres, Neurontin, phenobarbital, Suboxone, and ibuprofen. The applicant was placed off of work, on total temporary disability. On October 16, 2014, 8/10 neck and shoulder pain were appreciated. It was stated that the applicant had been discharged from an inpatient detoxification facility. The applicant was placed off of work, on total temporary disability. Clonidine, phenobarbital, and Suboxone were endorsed.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Clonidine 0.1mg #60:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Detoxification Page(s): 42. Decision based on Non-MTUS Citation UpToDate.com, Medically Supervised Opioid Withdrawal During Treatment for Addiction article

**Decision rationale:** While the MTUS does not specifically address the topic of clonidine for opioid detoxification purposes, page 42 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that detoxification is recommended for the purposes of withdrawing an applicant from a specific substance, generally psychoactive substances and/or opioids. Here, the applicant does have a history of opioid dependence. The applicant is apparently in the process of trying to detoxify off of numerous opioids, including morphine. The comprehensive literature survey conducted by UpToDate.com in medically supervised opioid withdrawal during treatment of addiction notes that clonidine has often been used with naloxone as part of a protocol for opioid detoxification purposes. While UpToDate notes that clonidine is not approved by the FDA for opioid withdrawal purposes, UpToDate notes that clonidine is, in fact, commonly used for this purpose. Here, the request was initiated approximately one week after the applicant was discharged from an inpatient detoxification facility. Continuing clonidine to facilitate the opioid detoxification on or around the date in question was indicated. Therefore, the request was medically necessary.

**Phenobarbital 32.4mg tablets, QTY: 120:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Weaning of Medications Page(s): 124. Decision based on Non-MTUS Citation Clinical Guide to the Diagnosis and Treatment of Mental Disorders, Michael First, et al, Chapter 24, page 242, High-dosed withdrawal section.

**Decision rationale:** In this case, it appeared, based on the attending provider's description of events, that phenobarbital was being employed for weaning or tapering purposes, to help the applicant taper off of Valium, a benzodiazepine anxiolytic. While the MTUS does not specifically address the topic of phenobarbital for benzodiazepine weaning purposes, page 124 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that phenobarbital can be employed to "prevent withdrawal" associated with Carisoprodol discontinuation. The textbook Clinical Guide to the Diagnosis and Treatment of Mental Disorders notes in Chapter 24, page 242 that "for discontinuation of benzodiazepines or non-benzodiazepine hypnotics that are being used at dosages above those generally prescribed, one pharmacotherapy strategy is to substitute phenobarbital for a stabilization period of three to seven days' period." The textbook Clinical Guide to the Diagnosis and Treatment of Mental Disorders also notes in Chapter 24, page 242 that "substitution of phenobarbital can also be used to withdrawal patients who have lost control of their benzodiazepine use or who are polydrug-dependent. Phenobarbital substitution has a broadest use for all sedative, hypnotic, or anxiolytic drug dependencies and is widely used in drug treatment programs." In this case, the applicant did have a variety of issues with poly drug dependence which apparently culminated in the applicant being admitted to an inpatient detoxification facility. Here, the applicant was apparently hospitalized for opioid and benzodiazepine dependence. The applicant was apparently using a variety of sedative and hypnotic agents, including Ambien and Valium. It appeared that phenobarbital was being endorsed on or around the date in question for benzodiazepine weaning or benzodiazepine tapering purposes. Such usage is compatible with the textbook Clinical Guide to the Diagnosis and Treatment of Mental Disorders and, by analogy, is also supported by page 124 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was medically necessary.

**Suboxone 8mg, 2mg SL film; QTY: 90:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 27.

**Decision rationale:** As noted on page 27 of the MTUS Chronic Pain Medical Treatment Guidelines, Suboxone is "recommended" in the treatment of opioid agonist dependence. Here, the applicant did apparently have issues with dependence to various and sundry opioid agents, including long and short-acting morphine. These issues were so severe that they culminated in the applicant being admitted to an inpatient detoxification facility. Introduction of Suboxone was indicated on or around the date in question to facilitate the applicant's weaning off of opioids altogether. Therefore, the request was medically necessary.

**Morphine Sulfate ER 60mg, QTY: 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines When to Discontinue Opioids; When to Continue Opioids Page(s): 79; 80.

**Decision rationale:** As noted on page 79 of the MTUS Chronic Pain Medical Treatment Guidelines, applicants who demonstrate no overall improvement in function should appropriately discontinue opioids. In this case, the applicant does fail to meet criteria set forth on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines for continuation of opioid therapy. Specifically, the applicant is off of work. The applicant has failed to return to work, despite ongoing morphine usage. The applicant remained off of work, on total temporary disability, on or around the date in question. The applicant continues to report complaints of severe pain, in the 8-10/10 range, despite ongoing morphine consumption. The attending provider failed to elaborate or expound upon any material improvements in function achieved as a result of ongoing morphine usage. Finally, the attending provider wrote on his October 16, 2014 progress note that he intended for the applicant to discontinue morphine and MS Contin and use Suboxone as a transitory step toward weaning off of opioids altogether. For all of the stated reasons, then, the request for morphine extended release was not medically necessary.

**Morphine Sulfate IR 30mg, QTY: 180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines When to Continue Opioids Page(s): 80.

**Decision rationale:** As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain achieved as a result of the same. Here, however, the applicant is off of work, on total temporary disability. The applicant's pain complaints are consistently described as severe, in the 8-10/10 range, despite ongoing opioid usage, including ongoing morphine immediate release usage. The attending provider has failed to elaborate or expound upon any material improvements in function achieved as a result of ongoing morphine usage. Finally, the attending provider wrote on his October 16, 2014 progress note that he intended for the applicant to wean off of morphine and use Suboxone as a transitory step toward weaning off of opioids altogether. Discontinuing morphine was, thus, a more appropriate option than continuing the same, for all of the stated reasons. Therefore, the request was not medically necessary.