

Case Number:	CM14-0022758		
Date Assigned:	06/11/2014	Date of Injury:	01/15/2009
Decision Date:	07/21/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	02/24/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 56-year-old female with a reported injury on 01/15/2009. The mechanism of injury was described as a fall. The clinical note dated 10/22/2013 reported that the injured worker complained of right hip pain that radiated to her lower back. Upon physical examination, the injured worker had mild pain with extension of the lumbar spine. Mild tenderness was noted per palpation of the right lateral hip. It was reported the injured worker's right shoulder had full range of motion without tenderness. The injured worker's prescribed medication list included Synthroid, amithiozone, Protonix, and naproxen. The injured worker's diagnoses included trochanteric bursitis to the right hip; compensatory mid and lower back pain with facet arthritis, and early instability lumbar spine to the L5-S1; compensatory right shoulder pain with partial thickness rotator; left shoulder pain. The provider requested Butrans 10 mcg/hour patch; the rationale was not provided within the clinical notes. The request for authorization was submitted on 02/24/2014. The injured worker's prior treatments included physical therapy and home exercise program. The dates and amount of therapy sessions were not provided in the clinical note.

IMR ISSUES, DECISIONS AND RATIONALES

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

BUTRANS 10 MCG/HOUR #4, 28 DAY SUPPLY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26-27.

Decision rationale: The request for Butrans 10 mcg-hour #4, 28-day supply is non-certified. The injured worker complained of right hip pain that radiated to her lower back. The treating physician's rationale for Butrans patch was not provided in the clinical notes. The California MTUS Guidelines recommend buprenorphine 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. Per the guidelines, buprenorphine is for treating opiate addiction or utilized for chronic pain post detoxification of opiate addiction. There is a lack of clinical information indicating that the injured worker was on an opiate or a narcotic. The treating physician's rationale for the Butrans patch was not provided within the clinical documentation. Given the information provided, there is insufficient evidence to determine appropriateness to warrant medically necessary; therefore, the request is non-certified.