

Case Number:	CM14-0126791		
Date Assigned:	08/13/2014	Date of Injury:	06/18/2009
Decision Date:	02/28/2015	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	08/11/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Colorado
 Certification(s)/Specialty: Family Practice

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 39 year old male who suffered an unknown work related injury on 06/18/09. His complaints include chronic neck and low back pain. His diagnoses include lumbar disc displacement without myelopathy and degeneration of lumbosacral disc. He was treated with lumbar epidural steroid injection on 04/29/14 with pain relief such that he was able to discontinue his pain medications. His pain level post-procedure was reduced from 7/10 to 3/10 as of 5/6/2014. He also noted better range of motion and was able to perform more activities better and with less pain at that time. On exam, full range of motion was noted of the lumbar spine. The lumbar spine was non-tender to palpation at the lumbosacral junction. Patient's pain, per the records, returned, however and medication regimen has maintained patient. The treatment regimen as of July 2014 included Capsaicin cream, Ketamine cream, Naproxen, Orphenadrine-norflex ER and Buprenorphine SL troches. The requested treatment is Buprenorphine SL troches. This treatment was denied by the Claims Administrator on 07/17/14 and was subsequently appealed for Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Buprenorphine 0.25mg sub lingual troches #90 DOS 4/29/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine. Decision based on Non-MTUS Citation Official Disability Guidelines, When to discontinue Opioids

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 26-27, 79-80, 85, 88-89.

Decision rationale: Per the Guidelines, Buprenorphine, partial agonist-antagonist analgesic ("agents that stimulate the analgesic portion of opioid receptors while blocking or having little or no effect on toxicity") available in patch and oral formulations, is recommended for treatment of opiate addiction, and is as an option for treatment of chronic pain, especially after detoxification in patients who have a history of opiate addiction (see below for specific recommendations) Possible advantages to use of Buprenorphine 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) Per the Guidelines, Buprenorphine pharmacological and safety profile "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 effects of Buprenorphine when completely withdrawing patients from opioids. Buprenorphine, however, is known to cause a milder withdrawal syndrome compared to methadone and for this reason may be a better choice to maintain patient off pure opioid agonist. As with use of any opioid, the Guidelines recommend the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence." Per the Guidelines, Chelminski defines "serious substance misuse" as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work? Has patient had improved function and decreased pain with the opioids? Per the records supplied for review, there is no documentation of

consistent improvement in pain related to Buprenorphine. Furthermore, the records do not include a validated objective evaluation verifying functional improvement with the Buprenorphine. The records do include urine drug screens positive for cocaine, which makes patient high risk for aberrant drug taking behavior, with no documentation of discussion of that. While Buprenorphine can be used to manage opioid addiction, it is not indicated for treatment of illicit substance abuse. When Buprenorphine is used for chronic pain management, the same criteria apply for its use as for that of other opioids. Based on the records supplied for review, the patient has not achieved objective functional improvement or pain decrease, and the patient is at high risk for aberrant drug taking behavior which has not been adequately discussed / monitored. The request for Buprenorphine is not medically indicated.