

Case Number:	CM14-0154902		
Date Assigned:	09/24/2014	Date of Injury:	09/13/1997
Decision Date:	01/26/2015	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	09/22/2014

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 Internal 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:

This is 38-year old male who suffered an industrial related injury on 9/13/97. A physician's report dated 3/19/14 noted the injured worker had complaints of leg pain that was limiting his activities of daily living. The physical examination revealed tenderness to palpation over the right and left lumbar facets. A straight leg raise was positive on the right and pain was noted with extension and forward flexion. The disability status was noted to be permanent and stationary. A physician report on 7/24/14 states that the patient is able to care for his kids, help his kids with school projects, and do home chores when he takes his Suboxone pain medicine, but if he doesn't he is bed bound with intractable pain. It was noted that in the past he had been on Methadone, Morphine sulfate, Fentanyl patch, Norco, Vicodin, Oxycontin, Percocet, Soma, and Ambien, and had tried ESI to his back. It was noted that he was able to be weaned off his opioid meds and maintained on Suboxone. He had no desire to go back to the other addicting meds. On 9/3/14 another MD note stated that the patient's treatment regimen would include education, PT., psychological counseling, biofeedback, relaxation techniques, pain support group, nutrition, yoga, tai chi, and work support in addition to his pain medicine. A physician's report dated 10/20/14 noted the injured worker was status post anterior and posterior lumbar fusion at L5-S1 with removal of hardware and redo fusion. The physician noted the injured worker has developed severe neuropathic pain after he developed cauda equina syndrome. Diagnoses included chronic intractable lower back pain, cauda equina syndrome, severe neuropathic pain, chronic pain syndrome, and opioid dependence The injured worker was taking Suboxone film 8mg two sublingual twice per day. On 9/15/14 the utilization review (UR) physician modified the request for Suboxone 8mg #120 for the purpose of a trial taper. The UR stated that the clinical documentation did not show ongoing review and documentation of pain relief, functional status, appropriate medication use, or side effects. The UR physician also noted

the pain assessments in the documentation provided did not include the current pain level, the least reported pain over the period since last assessment, average pain level, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Therefore the request is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Suboxone 8mg, #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25, 26, 27, 75.

Decision rationale: Suboxone, or Buprenorphine, is a partial agonist antagonist which stimulates the analgesic portion of the opioid receptor while blocking or having little or no effect on toxicity and has a lower abuse potential than the opioids that are pure agonists. It is a Schedule 111 medication, a partial agonist at mu-receptor and antagonist at the kappa receptor. In Europe it has a transdermal formulation to treat chronic pain. Hallucinations and dysphoria can be caused. It is a recommended treatment of opioid addiction and an option in treating chronic pain, especially after detoxification of a patient with a history of opioid addiction. The advantages this drug has for treating chronic pain are 1-no analgesic ceiling,2-good safety profile, especially in regards to respiratory depression,3-low abuse potentation,4-ability to supervise opioid withdrawal, and 5- its antihyperalgesic effect. Suboxone is the recommended treatment for opioid addiction because of its unique pharmacological and safety profile. It encourages treatment adherence and reduces the possibility of overdose and abuse. It is as effective as Methadone in opioid maintenance treatment. However, few studies have been reported in its efficacy in completely withdrawing patients from opioids. In the above patient we note that he has failed pain control with back surgery and multiple other modalities, including ESI's of the back and multiple narcotic and non-narcotic medicines. He was successfully weaned off of these meds and maintained on Suboxone, which has a much better safety and side effect profile. With this med his MD noted he was able to function, but without it was bed bound. His MD plans to treat his pain with other modalities besides his medicine in order to further enhance his quality of life. The literature noted that Suboxone has been successful in enabling a patient to be titrated off of opioids but there is little known about its ability to have a patient completely withdrawn from opioids. Therefore, the Suboxone 8mg, #120 is medically necessary.