

Case Number:	CM14-0176770		
Date Assigned:	10/30/2014	Date of Injury:	03/06/2002
Decision Date:	03/05/2015	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/24/2014

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. 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 a 61 year old female who suffered a work related injury on 03/06/2002. The neck and right shoulder were secondary to cumulative trauma and the low back pain was due to a fall. A physician note, phone call, dated 09/25/2014 revealed diagnoses include syndrome cervicobrachial, neck pain and lumbago. The injured worker is "Permanent and Stationary". The Utilization Review dated 9/26/2014 documents the injured worker has had previous treatment with included physical therapy, restorative yoga, home exercise program, psychological treatment, acupuncture, trigger pint injections, occipital nerve blocks, cervical epidural steroid injections and medication. A Magnetic Resonance Imaging of the right shoulder reviewed on 6/30/2014 documented mild down sloping of the acromion. There was mild chronic tendinosis of the supraspinatus and subscapularis with undersurface spurring of the acromion and minimal subacromial bursitis. An EMG reviewed on 6/30/2014 documented cranial nerve 11 neuropathy which caused trapezius weakness dis cause in the scapular winging. The Utilization Review documents that according to the physician visit dated 6/30/2014 the injured worker complained of chronic neck, right shoulder, and back pain. She reported the pain was worse with increased activity and repetitive motion of the upper extremity. Medication helped with pain and function. Without medication, the injured worker would have a significant amount of pain, and would not be able to perform many activities of daily living. The injured worker's review of systems was significant for constipation, heartburn, anxiety and depression. She has scapular winging right-sided. The retrospective request is for buprenorphine 0.25mg, # 180. Utilization Review dated 09/26/2014 non-certified the retrospective request for

Buprenorphine 0.25mg, # 180 citing, California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines, and Official Disability Guidelines. This medication is not a first line therapeutic option for chronic pain. This medication is recommended for treatment of opiate addiction. It is also recommended as an option for chronic pain, especially after detoxification in patient who has a history of opiate addiction. There is no evidence of prior opiate addiction noted in the record review; the necessity of this medication is not really substantiated. Non-certification does not imply abrupt cessation for a patient who may be at risk for withdrawal symptoms. Should the missing criteria necessary to support the medical necessity of this request remain unavailable, the discontinuance should include tapering prior to discontinuing avoiding withdrawal symptoms. Therefore the retrospective request for Buprenorphine 0.25mg for the date of service 6/30/2014 is not medically necessary or appropriate.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription for buprenorphine 0.25mg (DOS 6/30/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26-27. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain updated 07/10/2014

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

Decision rationale: This patient presents with chronic neck and low back pain. The current request is for BUPRENORPHINE (dos 6/30/14). The Utilization review denied the request stating that there is no evidence of prior opiate addiction. The MTUS Guidelines page 26-27 has the following regarding buprenorphine, recommended 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 (see below for specific recommendation). The medical file provided for review includes one progress and provides no discussion as to why this medication is prescribed. As discussed in MTUS page 26 and 27, this medication is intended for treatment of opiate addiction or as an option for chronic pain for patients who have a history of opiate addiction. The treating physician has provided no such discussion; therefore, the requested buprenorphine IS NOT medically necessary