

Case Number:	CM15-0135712		
Date Assigned:	07/23/2015	Date of Injury:	01/15/2010
Decision Date:	09/24/2015	UR Denial Date:	07/09/2015
Priority:	Standard	Application Received:	07/14/2015

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:

The injured worker is a 66 year old male, who sustained an industrial injury on 1-15-2010. He reported low back pain. Diagnoses have included chronic pain due to trauma, lumbar spondylosis without myelopathy, post-laminectomy syndrome of the lumbar region, degeneration of lumbar or lumbosacral intervertebral disc, lumbago, myalgia and myositis and thoracic or lumbosacral neuritis or radiculitis unspecified. Treatment to date has included surgery, physical therapy, H-wave and medication. According to the progress report dated 6-2-2015, the injured worker complained of back pain in the lower back and gluteal area. The pain radiated to the right foot. The injured worker had an antalgic gait. Exam of the lumbar spine revealed tenderness. There was moderate pain with range of motion. Authorization was requested for Suboxone and Restoril.

IMR ISSUES, DECISIONS AND RATIONALES

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

Suboxone 2mg -0.5mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids ongoing management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Buprenorphine Page(s): 60, 61, 76-78, 88, 89, 26-27.

Decision rationale: The patient presents with low back pain radiating to the thigh and right foot. The request is for SUBOXONE 2 MG-0.5 MG #120. Examination to the lumbar spine on 03/09/15 revealed pain with range of motion with radiation down the right thigh. Per 02/11/15 progress report, patient's diagnosis include myalgia and myositis, unspecified; diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled; lumbago; abnormality of the gait; lumbosacral spondylosis without myelopathy; post laminectomy syndrome of lumbar region; other pain disorders related to psychological factors; morbid obesity; thoracic or lumbosacral neuritis or radiculitis, unspecified; post traumatic stress disorder; degeneration of lumbar or lumbosacral intervertebral disc; chronic pain due to trauma; and COAT. Patient's medications, per 06/02/15 progress report include Hydrochlorothiazidine, Losartan, Metformin, Bupropion, Sertaline, Simvastatin, Aspirin, Lyrica, Suboxone, and Lisinopril. Patient is permanent and stationary. MTUS Guidelines pages 88 and 89, CRITERIA FOR USE OF OPIOIDS, states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief." MTUS pages 26-27, Buprenorphine section specifically recommends it for treatment of opiate addiction and also for chronic pain. Treater does not specifically discuss this medication. The utilization review letter dated 07/09/15 modified the request from #120 to one month supply. Review of the medical records provided indicate that the patient has been using Suboxone at least since 03/12/15. MTUS requires appropriate discussion of the 4A's. However, in addressing the 4A's, treater does not discuss how Suboxone significantly improves patient's activities of daily living with specific examples of ADL's. Analgesia is not discussed either, specifically showing significant pain reduction with use of Suboxone. No validated instrument is used to show functional improvement. Furthermore, there is no documentation nor discussion regarding adverse effects and aberrant drug behavior. There is no UDS, CURES nor opioid pain contract. Given the lack of documentation as required by MTUS, the request IS NOT medically necessary.

Restoril 7.5mg #20 x 2refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, under Insomnia treatment Pain (Chronic) Chapter, under Benzodiazepines.

Decision rationale: The patient presents with low back pain radiating to the thigh and right foot. The request is for RESTORIL 7.5 MG #20 x 2 REFILLS. Examination to the lumbar spine on

03/09/15 revealed pain with range of motion with radiation down the right thigh. Per 02/11/15 progress report, patient's diagnosis include myalgia and myositis, unspecified; diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled; lumbago; abnormality of the gait; lumbosacral spondylosis without myelopathy; post laminectomy syndrome of lumbar region; other pain disorders related to psychological factors; morbid obesity; thoracic or lumbosacral neuritis or radiculitis, unspecified; post traumatic stress disorder; degeneration of lumbar or lumbosacral intervertebral disc; chronic pain due to trauma; and COAT. Patient's medications, per 06/02/15 progress report include Hydrochlorothiazidine, Losartan, Metformin, Bupropion, Sertaline, Simvastatin, Aspirin, Lyrica, Suboxone, and Lisinopril. Patient is permanent and stationary. ODG-TWC Guidelines, Pain (Chronic) Chapter, under Insomnia treatment Section states, "FDA-approved benzodiazepines for sleep maintenance insomnia include temazepam (Restoril). These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events. Particular concern is noted for patients at risk for abuse or addiction. Benzodiazepines are similar in efficacy to benzodiazepine-receptor agonists; however, the less desirable side-effect profile limits their use as a first-line agent, particularly for long-term use." ODG-TWC Guidelines, Pain (Chronic) Chapter, under Benzodiazepines Section states, "Not recommended for long-term use (longer than two weeks), because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks." The MTUS Guidelines page 24, Benzodiazepine Section states, "Benzodiazepines are not recommended for long-term use because long-term efficacies are unproven and there is a risk of dependence." In this case, the patient continues with low back pain radiating to the thigh and right foot. Review of the medical records do not indicate a prior use of this medication and it appears that the treater is initiating it. However, this medication is indicated for insomnia which this patient does not present with. Furthermore, ODG and MTUS do not support long-term use of this medication due to risk of tolerance, dependence, adverse events and side-effect profile, and the request for #20 with 2 refills does not indicate short-term use. Therefore, the request IS NOT medically necessary.