

Case Number:	CM15-0140215		
Date Assigned:	07/30/2015	Date of Injury:	08/23/2002
Decision Date:	09/25/2015	UR Denial Date:	07/14/2015
Priority:	Standard	Application Received:	07/20/2015

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 59 year old male, who sustained an industrial injury on 8-23-02. The injured worker was diagnosed as having lumbago, other back symptoms, long term use of other medications, spinal stenosis and therapeutic drug monitoring. Treatment to date has included oral medications including Gabapentin 600mg, Suboxone, Morphine and Oxycontin; topical Duragesic patch, epidural injections, facet blocks, physical therapy, acupuncture, transcutaneous electrical nerve stimulation (TENS) unit and home exercise program. (MRI) magnetic resonance imaging of lumbar spine performed on 11/29/10 revealed degenerative disc disease, congenital shortening of the pedicles resulting in cervical tightening of the spinal canal and circumferential disc bulges at multiple levels most prominently at L4-5 and L5-S1. Currently on 7-6-15, the injured worker notes a flare up of back pain after tripping over a suitcase; he also ran out of Suboxone the week prior and is having more pain, he notes he was having withdrawals at the same time as the flare up. He rates his pain 7-8 out of 10; he also continues to have pain in bilateral lower extremities. He has trialed high doses of opiates previously without much benefit. The provider noted he had asked him to discontinue his Suboxone as he was not getting pain relief. He is currently temporarily totally disabled. Physical exam performed on 7-6-15 revealed restricted range of motion of lumbar spine with diffuse tenderness and decreased sensation in left lateral portion of the leg compared to the right. The treatment plan included prescriptions for Prozac 20mg, Senna 2 tabs #120 and Suboxone 8mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Senna #120, prescribed 07/06/15: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain - Opioid-Induced constipation treatment.

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

Decision rationale: Based on the 7/6/15 progress report provided by the treating physician, this patient presents with unchanged low back pain rated 7-8/10 on VAS scale, radiating down posterior legs into the calf with weakness, burning sensation, and numbness/tingling in lower extremities. The treater has asked for Senna #120, prescribed 07/06/15 on 7/6/15. The patient's diagnoses per Request for Authorization form dated 7/6/15 are lumbago, other back symptoms, encounter for long term use of other medications, encounter for therapeutic drug monitoring, spinal stenosis not otherwise specified. The patient is s/p bilateral L5-S1 ESI from February 2015 which gave 70% improvement until recently per 6/8/15 report. The patient discontinued suboxone last week as it was not providing pain relief, and has had withdrawals that have flared up recently per 7/6/15 report. The patient states that Prozac helps keep mood stable, and Tizanidine helps with spasms but has been denied per 7/6/15 report. The patient has had benefit from prior epidural injections, but has not benefited from physical therapy per 6/8/15 report. The patient's work status is not included in reports. MTUS, Initiating Opioids Section, page 77, states: (d) Prophylactic treatment of constipation should be initiated." Opioid induced constipation is a common adverse side effect of long-term opioid use." MTUS, Opioids for osteoarthritis Section under "Short Term Use", pg. 83: Benefits of opioids are limited by frequent side effects (including nausea, constipation, dizziness, somnolence and vomiting). (Stitik, 2006) (Avouac, 2007) (Zhang, 2008) In regard to the requested Senna for the management of this patient's Opioid associated constipation, the medication is not necessary as continued opiate usage is not substantiated. Such medications are appropriate interventions for those undergoing long-term opiate use, though in this case the associated Suboxone is being recommended for continued use. Therefore, this request for Senna IS medically necessary.

Suboxone 8mg #60, prescribed 07/06/15: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine, opioids. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26-27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter under Buprenorphine for opioid dependence, Pain Chapter under Buprenorphine for chronic pain.

Decision rationale: Based on the 7/6/15 progress report provided by the treating physician, this patient presents with unchanged low back pain rated 7-8/10 on VAS scale, radiating down posterior legs into the calf with weakness, burning sensation, and numbness/tingling in lower extremities. The treater has asked for Suboxone 8mg #60, prescribed 07/06/15 on 7/6/15. The patient's diagnoses per Request for Authorization form dated 7/6/15 are lumbago, other back symptoms, encounter for long-term use of other medications, encounter for therapeutic drug monitoring, spinal stenosis not otherwise specified. The patient is s/p bilateral L5-S1 ESI from February 2015 which gave 70% improvement until recently per 6/8/15 report. The patient

discontinued suboxone last week as it was not providing pain relief, and has had withdrawals that have flared up recently per 7/6/15 report. The patient states that Prozac helps keep mood stable, and Tizanidine helps with spasms but has been denied per 7/6/15 report. The patient has had benefit from prior epidural injections, but has not benefited from physical therapy per 6/8/15 report. MTUS Buprenorphine section, pages 26-27: 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 recommendations). A schedule-III controlled substance, buprenorphine is a partial agonist at the mu-receptor (the classic morphine receptor) and an antagonist at the kappa-receptor (the receptor that is thought to produce alterations in the perception of pain, including emotional response). In recent years, buprenorphine has been introduced in most European countries as a transdermal formulation ("patch") for the treatment of chronic pain. Proposed advantages in terms of pain control 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 anti-hyperalgesic effect (partially due to the effect at the kappa-receptor). (Kress, 2008) (Heit, 2008) (Johnson, 2005) (Landau, 2007) ODG Pain (Chronic) Chapter under Buprenorphine for opioid dependence: Recommended for selected patients for treatment of opioid dependence.... Original studies investigate the use of buprenorphine for treatment of heroin addiction and research is still ongoing for use in populations with prescription drug abuse, or with comorbid dependency and chronic pain. ODG Pain Chapter under Buprenorphine for chronic pain: Recommended as an option for treatment of chronic pain (consensus based) in selected patients (not first-line for all patients). Suggested populations: (1) Patients with a hyperalgesic component to pain; (2) Patients with centrally mediated pain; (3) Patients with neurotic pain; (4) Patients at high-risk of non-adherence with standard opioid maintenance; (5) For analgesia in patients who have previously been detoxified from other high-dose opioids. Use for pain with formulations other than Butrans is off-label. Due to complexity of induction and treatment the drug should be reserved for use by clinicians with experience. This patient has been utilizing Suboxone since 1/21/15. According to progress report 6/8/15, the patient is "not sure if current dose of suboxone is working or not. He notes that he is down to 1/4 film twice a day. He will try tapering it to discontinuation this month." On 7/6/15 report, he has been having more pain, flare-ups, and withdrawals as he ran out of suboxone. He has trailed high doses of opiates previously without benefit per 7/6/15 report. The patient has had 6 months of usage of suboxone at dosage of 8mg 1/2film QD without benefit. The treater is requesting suboxone 8mg 1 film QD and then increase to 2QD if needed for pain control #60 per 7/6/15 report, which appears reasonable for patient's current withdrawal symptoms. The request IS medically necessary.