

<b>Case Number:</b>	CM15-0196156		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	09/17/2013
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	09/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2015

### 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: Montana, Oregon, Idaho  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 female who sustained an industrial injury on 9-17-13. A review of the medical records indicates she is undergoing treatment for back pain and lumbosacral spondylosis without myelopathy. Medical records indicate complaints of low back pain and "carpal tunnel syndrome" (9-9-15). The records indicate that her back pain is "from facet arthropathy". The physical exam (6-18-15) reveals "severe" tenderness to palpation of the lower lumbar spine. Lumbar range of motion is noted to be "moderately decreased". Faber test and the straight leg raise were negative. Bilateral facet load is positive. Motor strength is "5 out of 5" "overall" deep tendon reflexes are "intact". Diagnostic studies have included an MRI of the lumbar spine. Treatment has included physical therapy and medications. The injured worker reports that she would like to "be off" Hydrocodone. The treating provider suggested increasing the Butrans patch to 20mcg per hour, #4 with 3 refills, in order "to end" the Hydrocodone. The utilization review (9-23-15) includes a request for authorization of Butrans patch 20mcg per hour, #4 with 3 refills. The request was denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Butrans patch 20mcg/hr, #4 with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Buprenorphine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, dealing with misuse & addiction.

**Decision rationale:** CA MTUS/Chronic Pain Medical Treatment Guidelines, pages 26-27 recommends use of Buprenorphine as an option in the treatment of opiate addiction. Also recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction. 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). Butrans is recommended when used for treatment of opiate dependence, clinicians must be in compliance with the Drug Addiction Treatment Act of 2000. Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Opioid weaning should include the following: (a) Start with a complete evaluation of treatment, comorbidity, psychological condition; (b) Clear written instructions should be given to the patient and family; (c) If the patient cannot tolerate the taper, refer to an expert (pain specialist, substance abuse specialist); (d) Taper by 20 to 50% per week of original dose for patients who are not addicted (the patient needs 20% of the previous day's dose to prevent withdrawal); (e) A slower suggested taper is 10% every 2 to 4 weeks, slowing to a reductions of 5% once a dose of 1/3 of the initial dose is reached; (f) Greater success may occur when the patient is switched to longer-acting opioids and then tapered; (g) Office visits should occur on a weekly basis; (h) Assess for withdrawal using a scale such as the Subjective Opioid Withdrawal Scale (SOWS) and Objective Opioid Withdrawal Scale (OOWS); & (i) Recognize that this may take months. In this case the quantity of medication exceeds that recommended in the guidelines. After initiation of therapy weekly visits are required and dosages should be decreased as recommended. The documentation does not support that an appropriate weaning program as outlined by the guidelines is in place. Therefore the request is not medically necessary.