

<b>Case Number:</b>	CM15-0203445		
<b>Date Assigned:</b>	10/20/2015	<b>Date of Injury:</b>	11/20/2012
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	09/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2015

### 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 41 year old male, who sustained an industrial injury on 11-20-2012. The injured worker is undergoing treatment for cervical pain, cervical strain, lumbar degenerative disc disease (DDD), and lumbar radiculopathy. Medical records dated 8-21-2015 indicate the injured worker complains of back pain rated 8.5 out of 10 without medication. He reports quality of sleep is poor. Physical exam dated 8-21-2015 notes appearance of "moderate to severe pain," slow antalgic gait, cervical, thoracic and lumbar tenderness to palpation with spasm and decreased range of motion (ROM), lumbar facet loading, positive straight leg raise, right shoulder tenderness to palpation, positive Hawkin's and empty can's test, and right knee tenderness to palpation, crepitus, positive grind and McMurray's. The treating physician indicates non-compliant 6-13-2014 urinary drug screen (UDS) and that the injured worker took Norco from a past prescription and different provider. Treatment to date has included Tramadol, Baclofen, Gabapentin, Butrans patch and Nucynta. The original utilization review dated 9-29-2015 indicates the request for Butrans 15mcg #4 is non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Butrans 15mcg #4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, indicators for addiction, Opioids, specific drug list, Opioids, steps to avoid 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). Recommended. When used for treatment of opiate dependence, clinicians must be in compliance with the Drug Addiction Treatment Act of 2000. Buprenorphine's pharmacological and safety profile makes it an attractive treatment for patients addicted to opioids. Buprenorphine's usefulness stems from its unique pharmacological and safety profile, which encourages treatment adherence and reduces the possibilities for both abuse and overdose. Studies have shown that buprenorphine is more effective than placebo and is equally as effective as moderate doses of methadone in opioid maintenance therapy. Few studies have been reported on the efficacy of buprenorphine for completely withdrawing patients from opioids. In general, the results of studies of medically assisted withdrawal using opioids (e.g., methadone) have shown poor outcomes. Buprenorphine, however, is known to cause a milder withdrawal syndrome compared to methadone and for this reason may be the better choice if opioid withdrawal therapy is elected. In this case, the worker was injured in 2012. He is being treated for neck, low back and hip pain. He has been treated with opioids for an unspecified time. He has demonstrated noncompliance with prescribed meds as evidenced by previous urine drug screens. He exhibits aberrant behavior and violation of opioid contract. However, the documentation does demonstrate a failure of previous attempts at narcotic weaning with standard methods. Withdrawal symptoms are documented. Therefore the justification for the requested medication is supported by the guidelines, however the notes do not document a weaning process. The note from 7/10/15, 7/31/15 and 8/21/15 increased the dose from 10mcg to 15 mcg and his Nucynta dose remained the same. Furthermore, the documentation does not lay out a timetable for weaning. Therefore, the medication use is not supported by the guidelines and the request is not medically necessary.